

13862, CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b ?			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4835 Langdrum Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Herbert Middle F. Last Aldridge				4. DATE OF DEATH Month December Day 12, Year 19 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/26/1892	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Lithographer				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
11. BIRTHPLACE (State or foreign country) Conn.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Thomas Aldridge				14. MOTHER'S MAIDEN NAME Augusta Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT wife				Address Chevy Chase, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 yrs.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1946 , 19____ to 12/12 , 19 59 that I last saw the deceased alive on 12/6 , 19 59 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1728 Mass Ave N.W. Washington D.C.							
ACTUAL SIGNATURE John H. Schumacher				M.D. 1728 Mass Ave N.W. Washington D.C.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMAINS (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
burial		12/15/59		Ft. Lincoln Cemetery		Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				24a. REC'D BY REGISTRAR DATE DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cherry Coast

63rd Cavalry

1st Cavalry

1st Cavalry

1st Cavalry

1st Cavalry

Coronel Thompson
Artillery 1st Division

1941

John. J. [Signature]

1941

1st Cavalry

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13858

CERTIFICATE OF DEATH

13797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS REST HOME		d. STREET ADDRESS 7701 GEORGIA AVENUE, N.W.	
3. NAME OF DECEASED (Type or print) First EDGAR Middle RICHBELL Last ALLABAND		4. DATE OF DEATH Month DEC. Day 11 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/72
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR: Months 87 Days 87 Hours 87 Min. 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST (retired)		10b. KIND OF BUSINESS OR INDUSTRY Retail Druggist	
11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM R. ALLABAND		14. MOTHER'S MAIDEN NAME MARY KINNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-24-8593	
17. INFORMANT Mrs. Emma C. Allaband, 7701 Ga. Ave., N.W.		Address Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 26 , 19 59 , to December 10, 1959 , that I last saw the deceased alive on December 9, 1959 , and that death occurred at 1:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James Coleman M.D.		ADDRESS (Street, city or town, state) 733 Sigo Avenue Silver Spring, Md.	
PHYSICIAN'S NAME (Type) JAMES R. COLEMAN		DATE SIGNED 12/11/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/14/59	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond G. Ziska		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DEC 16 '59
		24b. REGISTRAR'S SIGNATURE C. H. S. H. H.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13798

Reg. Dist. No.

13864

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SILVER SPRING c. LENGTH OF STAY IN 1b 1 yr., 2 mos.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARILEA NURSING HOME		d. STREET ADDRESS 8819 Second Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JERUSHA		4. DATE OF DEATH Month DECEMBER Day 27 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/26/80
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert L. Nash	
14. MOTHER'S MAIDEN NAME Susan Poor		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Geo. H. Manning, 8819 2nd Ave., Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs ?		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 58 to 27 Dec , 19 59 , that I last saw the deceased alive on 22 Dec , 19 59 , and that death occurred at 8:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Aud		ADDRESS (Street, city or town, state) 9006 Glenville Rd Silver Spring Md DATE SIGNED 12/27/59	
PHYSICIAN'S NAME (Type) WILLIAM D. AUD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/30/59	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. BUMPHREY, INC. Raymond A. Jaska		24a. REC'D BY REGISTRAR DATE DEC 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kniss			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1914

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1869		Boston, Mass.	
Cause of Death		Disease		Duration		Time of Day		Place of Death	
Heart Disease		Myocardial Infarction		2 Weeks		10:30 AM		Home	
Occupation		Marital Status		Single		Color		Race	
Teacher		Married		White		White		Caucasian	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Disease	
Jan 15, 1914		10:30 AM		Home		Heart Disease		Myocardial Infarction	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13865

CERTIFICATE OF DEATH

13799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>25 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>453 Walk Street</u>			
3. NAME OF DECEASED (Type or print) First <u>THEODORE</u> Middle <u>ROOSEVELT</u> Last <u>ARTIS, JR.</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>10</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 6, 1945</u>		9. AGE (In years last birthday) <u>14</u> yrs.	10. IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Theodore R. Artis, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Gray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis, Lungs, Post Operative</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atrioventricular Canal</u> Congenital DUE TO (c) <u>Mitral Insufficiency</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>November 15, 19 59</u> , to <u>December 10, 19 59</u> , that I last saw the deceased alive on <u>December 10, 19 59</u> , and that death occurred at <u>4:12 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Roland Folse, M.D.</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>12-11-59</u>			
PHYSICIAN'S NAME (Type) <u>ROLAND FOLSE, M.D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>12-11-59</u>		<u>Norfolk</u>		<u>Va.</u>	
23. FUNERAL-DIRECTOR'S SIGNATURE <u>Frazers Funeral Home Inc.</u>				ADDRESS <u>384-R.D. Ave. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 14 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

13866

CERTIFICATE OF DEATH

13800

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb 162 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 7219 Spruce Avenue			
3. NAME OF DECEASED (Type or print) First Patricia Middle Elaine Last Atler				4. DATE OF DEATH Month December Day 1 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 January 1952	
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Months 7 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry D. Atler, Jr.				14. MOTHER'S MAIDEN NAME Margaret Barnett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Wilms's Tumor with extensive involvement of lungs, 180 x DUE TO liver and pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia DUE TO unknown (c) _____						INTERVAL BETWEEN ONSET AND DEATH 15 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from June 22, 1959 , to December 1, 1959 , that I last saw the deceased alive on December 1, 1959 , and that death occurred at 1:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Arthur R. Rothman M.D.				The Clinical Center 12/1/59			
PHYSICIAN'S NAME (Type) Arthur R. Rothman M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 4, 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll Wood Rd				24a. REC'D BY REGISTRAR DATE DEC 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SECRET

11

Emergency

Very low

Within 100 miles

Emergency

100 days

Within 100 miles

The Clinical Center, Bethesda, Md.

100 days

Emergency

100 days

Within 100 miles

Within 100 miles

Emergency

100 days

Emergency

Emergency

The Clinical Center, Bethesda, Md.

Emergency

Emergency

Emergency

Emergency

The Clinical Center, Bethesda, Md.

Emergency

Emergency

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

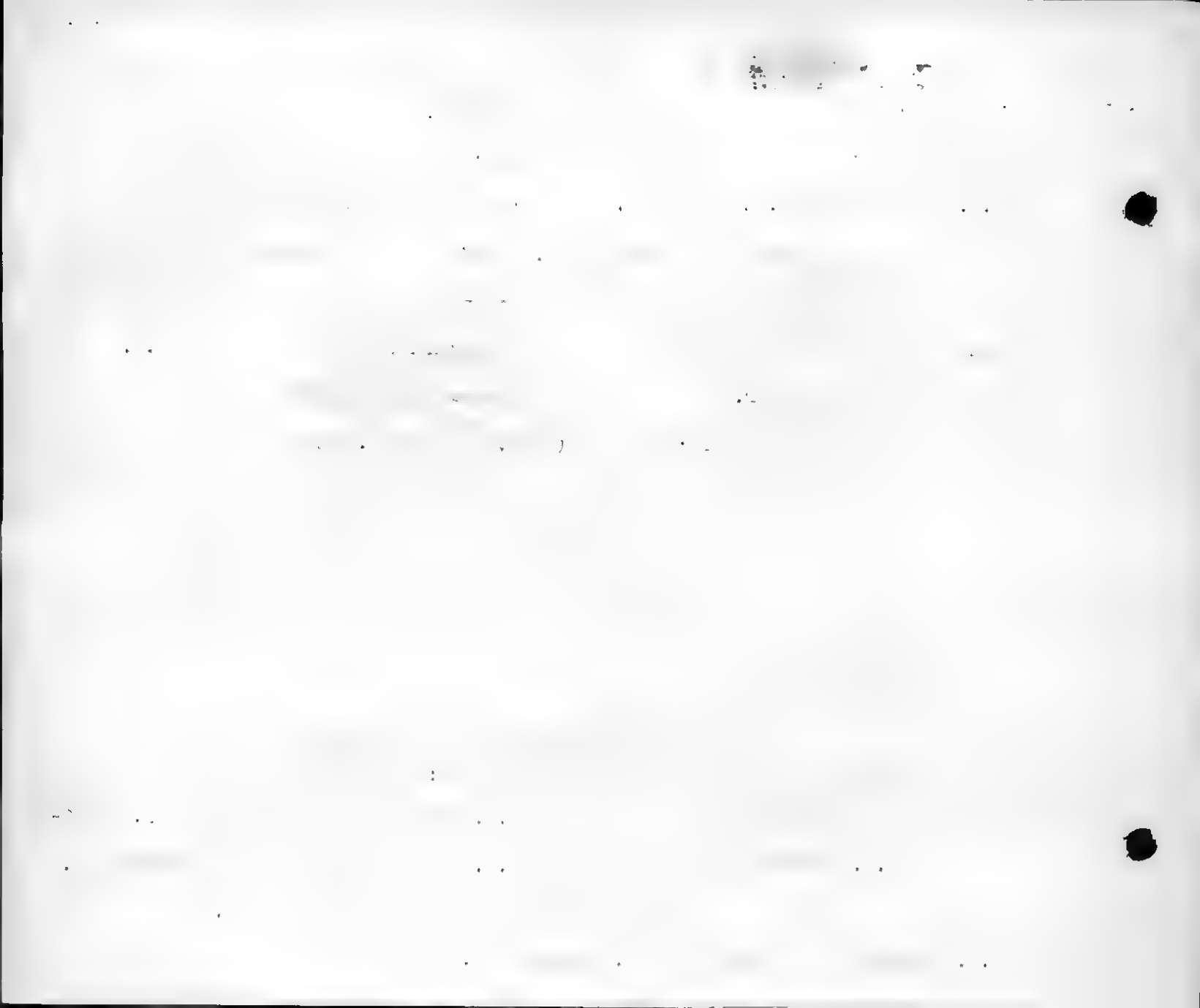
CERTIFICATE OF DEATH

Reg. Dist. No. 215

13867

13801

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Virginia		b. COUNTY Fairfax		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairfax		d. STREET ADDRESS 1601 East Lee Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Joseph George Jr. BARN		4. DATE OF DEATH Month December Day 1 Year 1959		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-19-59		9. AGE (In years last birthday) 12 yrs.		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min 12		11. IF UNDER 24 HRS Months 12 Days 12 Hours 12 Min 12															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Joseph George Barna Sr.		14. MOTHER'S MAIDEN NAME Jacqueline OSTRANDER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Joseph G. Barna		18. ADDRESS Same as #2													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		19. INTERVAL BETWEEN ONSET AND DEATH In testicular atrophy		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 570.5		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 570.5		20c. TIME OF INJURY Hour 5 a.m. 19 p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda Md.		20f. (City or town) Bethesda Md.		(County) Fairfax		(State) Virginia											
21. I certify that I attended the deceased from 26 November , 19 59 , to 1 December , 19 59 , that I last saw the deceased alive on 1 December , 19 59 , and that death occurred at 1:25 PM , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.		23. DATE SIGNED 12-2-59		24. ACTUAL SIGNATURE W.D. Hooper		25. PHYSICIAN'S NAME (Type) W.D. HOOPER LT MC USN		26. ADDRESS U.S. Naval Hospital, NNMC, Bethesda Md.		27. BIRTHPLACE (State or foreign country) Maryland		28. CITIZEN OF WHAT COUNTRY? U.S.		29. FATHER'S NAME Joseph George Barna Sr.		30. MOTHER'S MAIDEN NAME Jacqueline OSTRANDER		31. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		32. SOCIAL SECURITY NO. None		33. INFORMANT (Father) Joseph G. Barna		34. ADDRESS Same as #2					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-4-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington Va.		23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		24. ADDRESS 1557 Wisconsin Ave. Bethesda Md.		25. REC'D BY REGISTRAR DEC 4 '59		26. REGISTRAR'S SIGNATURE Arthur S. Thomas		27. BIRTHPLACE (State or foreign country) Maryland		28. CITIZEN OF WHAT COUNTRY? U.S.		29. FATHER'S NAME Joseph George Barna Sr.		30. MOTHER'S MAIDEN NAME Jacqueline OSTRANDER		31. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		32. SOCIAL SECURITY NO. None		33. INFORMANT (Father) Joseph G. Barna		34. ADDRESS Same as #2	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

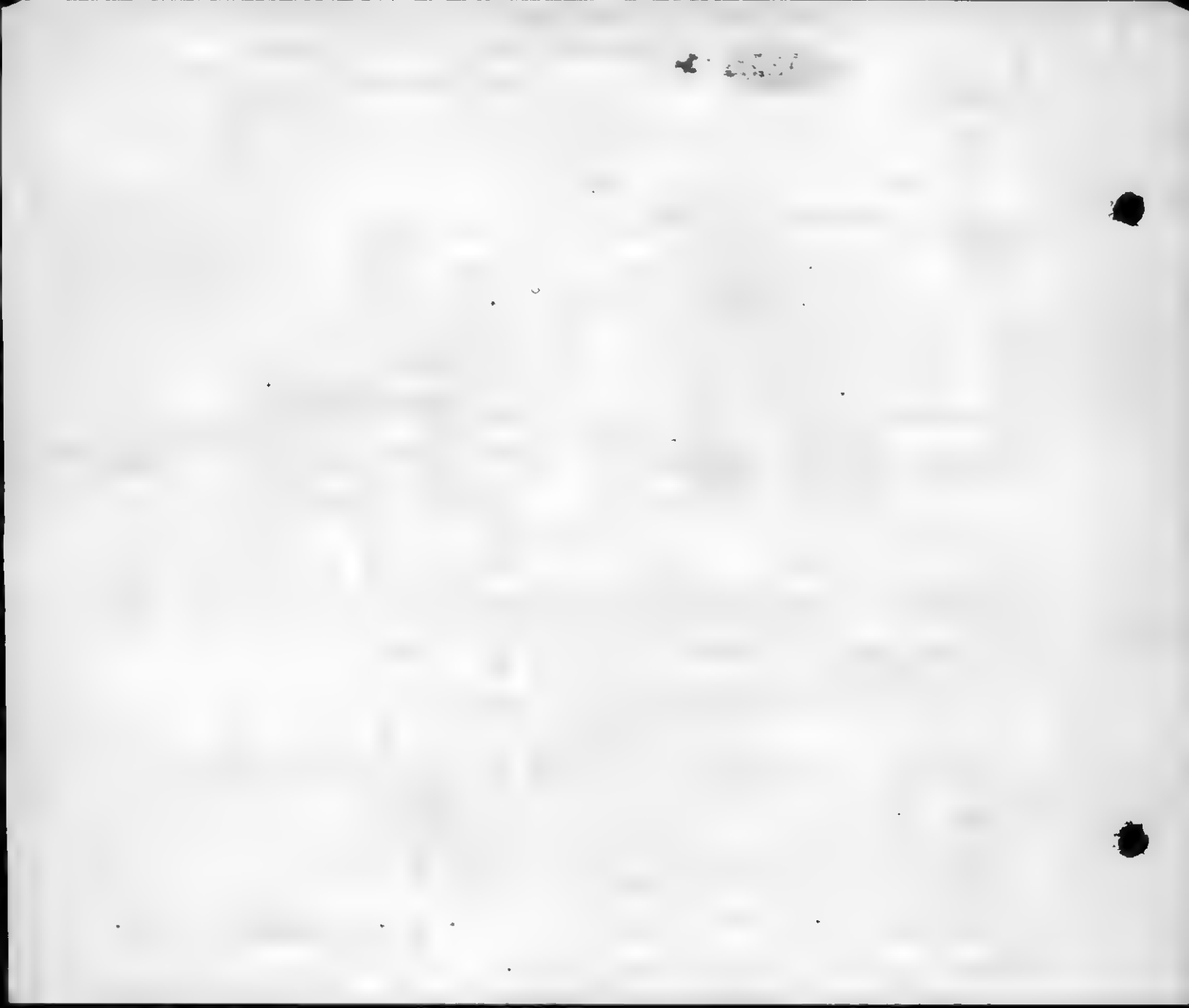
13802

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood R-1</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood R-1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Redland</u>				d. STREET ADDRESS <u>Redland</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Virgil Clark Barnhouse</u>				4. DATE OF DEATH Month Day Year <u>Dec 25 - 1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 22 1911</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest C. Barnhouse</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Copper</u> XXXXXXXXXXXX			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>577-16-974</u>		17. INFORMANT <u>Enter my Barnhouse (wife)</u> <u>Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Indeal in bed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				DATE SIGNED <u>12-25-59</u>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCANT</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 28, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville Meth. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>				ADDRESS <u>Laytonsville 11e, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 31 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. H. S. Frank</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13826

CERTIFICATE OF DEATH

Reg. Dist. No. 13808

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASH b. COUNTY D.C.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park Md.			c. LENGTH OF STAY IN 1b 3 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. 47X3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shannon Rest Home				d. STREET ADDRESS 949 Longfellow St, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Grace Virginia Beard.				4. DATE OF DEATH Month 9/ Day 12/ Year 5/59				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/2/1875		
9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Leesburg Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Gheen				14. MOTHER'S MAIDEN NAME Unknown.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Bertie M Caffrey, 949 Longfellow St N.W.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1956 to 5 DEC 1959 that I last saw the deceased alive on 4 Dec 1959 and that death occurred at 5:06 AM from the causes and on the date stated above.								
ACTUAL SIGNATURE William E. Lind M.D.				ADDRESS (Street, city or town, state) 906 Colisville Rd DATE SIGNED 12/5/59				
PHYSICIAN'S NAME (Type) Silver Spring Md								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City town, or county) (State) Pr Georges Co Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W. K. Huntman & Son				ADDRESS 5732 Georgia Ave N.W.		24a. REC'D BY REGISTRAR DEC 8 '59		
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

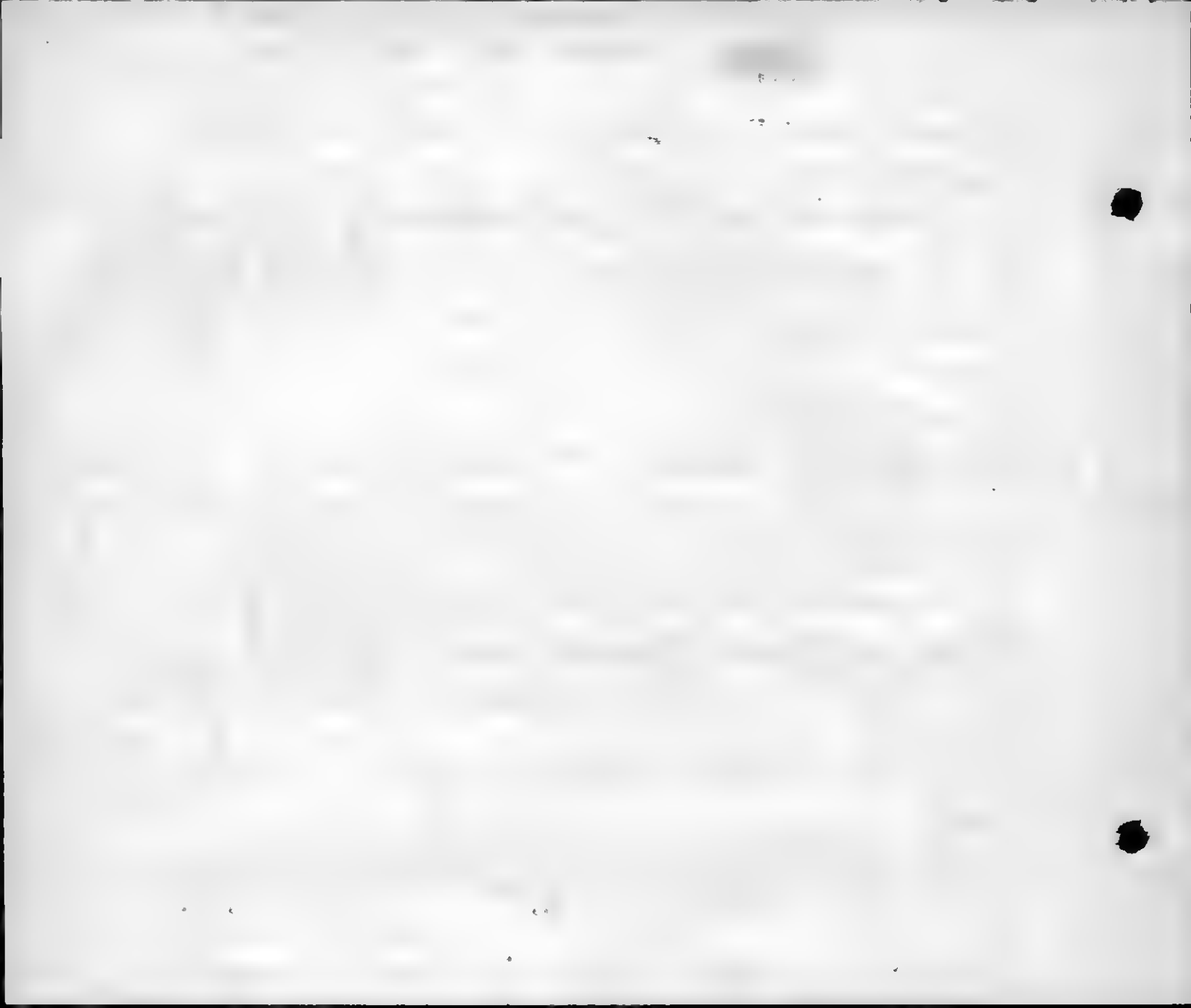
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13804

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg - R-2</u>		c. LENGTH OF STAY IN 1b <u>25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Emory Grove</u>				d. STREET ADDRESS <u>Emory Grove</u>			
3. NAME OF DECEASED (Type or print) <u>Arthur Roosevelt Bell Jr</u>				DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24, 1959</u>		9. AGE (in years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>1</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Arthur R. Bell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Neal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mary Bell (mother)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>None</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) <u>Emory Grove, Md.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-25-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove.,</u>		22d. LOCATION (City, town, or county) <u>Emory Grove, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swartz</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>None</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

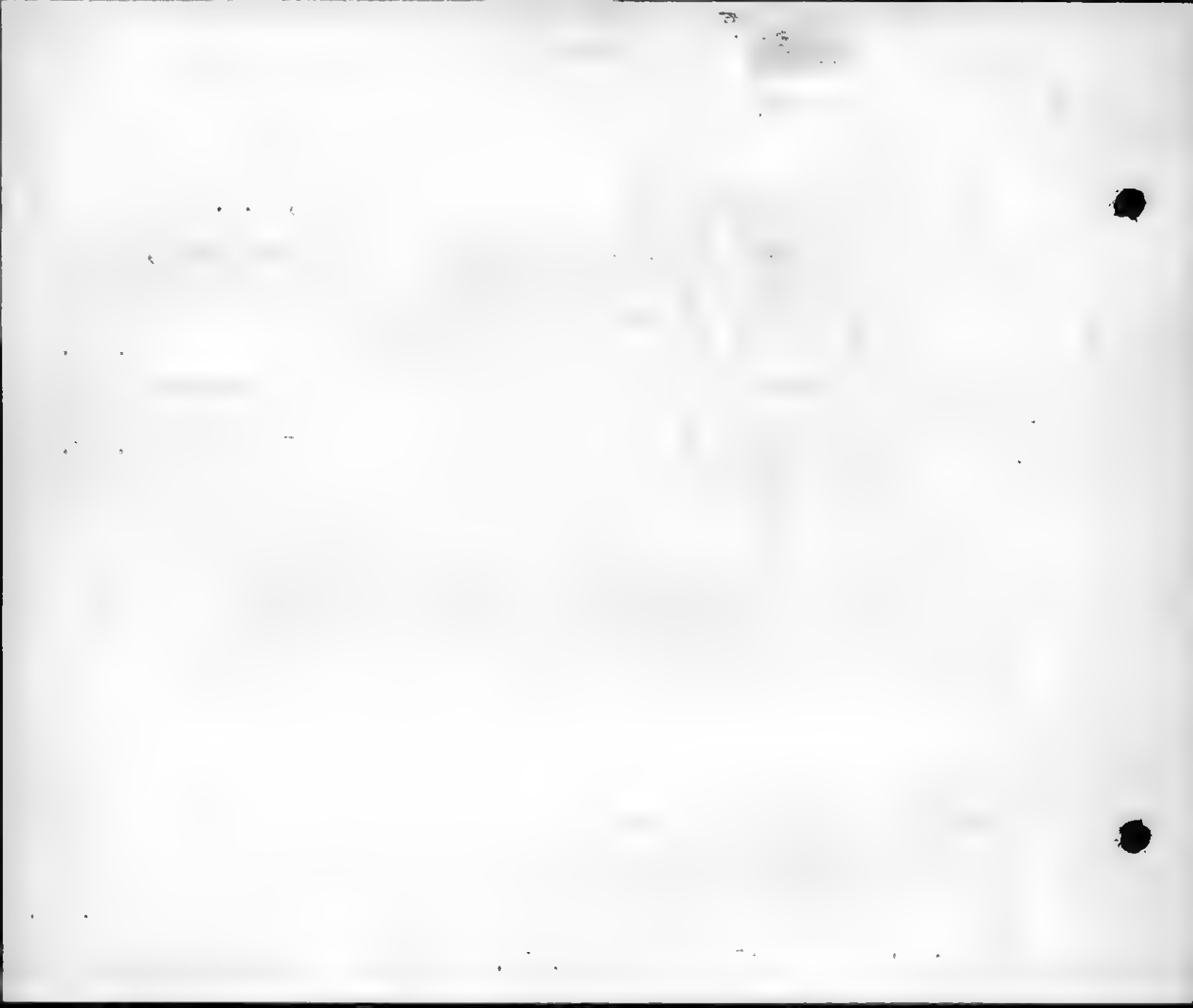
Reg. Dist. No.

13805

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-12	
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION Oak Haven Rest Home		d. STREET ADDRESS 1920 Park Road, N.W.	
3. NAME OF DECEASED (Type or print) First Mary Middle Frances Last Bode		4. DATE OF DEATH Month December Day 3 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/9/1866
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kaltenbach		14. MOTHER'S MAIDEN NAME Wilhelmenia Hockenheimer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no	
INFORMANT Oak Haven Rest Home-517 Albany Avenue Takoma Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pneumonia, lobar. DUE TO (c) Cardiovascular decompensation & arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 2 days. 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Age			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 52 , to Dec 3 , 19 59 , that I last saw the deceased alive on 12/2/59 , 19 59 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. A. Thomas MD		ADDRESS (Street, city or town, state) DATE SIGNED 12/3/59	
PHYSICIAN'S NAME (Type) S. A. Thomas MD		Washington D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/5/59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.-2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR DEC 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13870

1. PLACE OF DEATH a. COUNTY <u>MONTCOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTCOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS</u>		d. STREET ADDRESS <u>1502 DOMER AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN FREDERICK BOETTCHER</u>		4. DATE OF DEATH Month Day Year <u>Dec 14 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-72</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN US MARINE BAND Retd Wash DC</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Jachim Boettcher</u>		14. MOTHER'S MAIDEN NAME <u>Mary Engle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW2 1937</u>		16. SOCIAL SECURITY NO. <u>-</u>	
INFORMANT <u>Albert & Catherine</u>		Address <u>502 Homer Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion.</u> <u>420.1</u> DUE TO (b) <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>?</u> <u>2 "</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, amputated both legs.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>Dec 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 9</u> , 19 <u>59</u> , and that death occurred at <u>12:10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter K. Angermeier</u> M.D.		ADDRESS (Street, city or town, state) <u>6300 43rd St, NW, Wash. D.C.</u> DATE SIGNED <u>12/14/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12 16 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u>		ADDRESS <u>4812 G. Ave NW</u>	24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Albert & Catherine</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



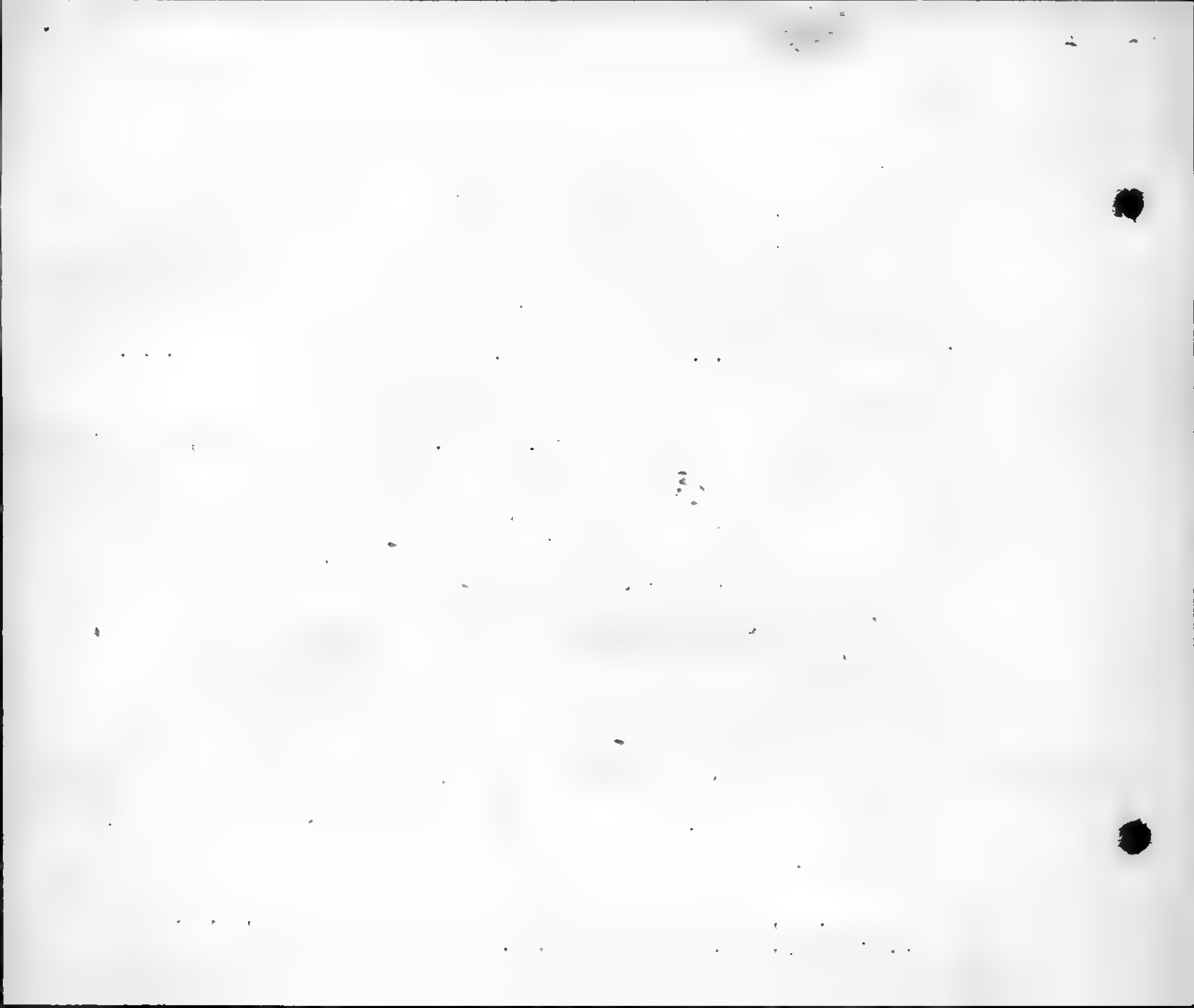
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13823 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No.

13807

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>2 weeks</u>				d. STREET ADDRESS <u>1232 Dale Drive</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Silas</u> Middle <u>Edward</u> Last <u>Booth</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1959</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-83</u>		9. AGE (In years last birthday) <u>76</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Agriculture Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Booth</u>				14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT Address <u>Mrs. Sarah M. Booth, 232 Dale Drive, Silver Spring, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery insufficiency</u>						<u>13 days.</u>	
DUE TO (b) <u>Arteriosclerotic heart disease, coronary</u>						<u>13 days.</u>	
DUE TO (c) <u>thrombosis and myocardial infarction</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Calafic aortic stenosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>Dec 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 24</u> , 19 <u>59</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u>						ADDRESS (Street, city or town, state) <u>M.D. 8237 Georgia Ave Silver Spring Md</u>	
DATE SIGNED <u>Dec 25 59</u>							
PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 29, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

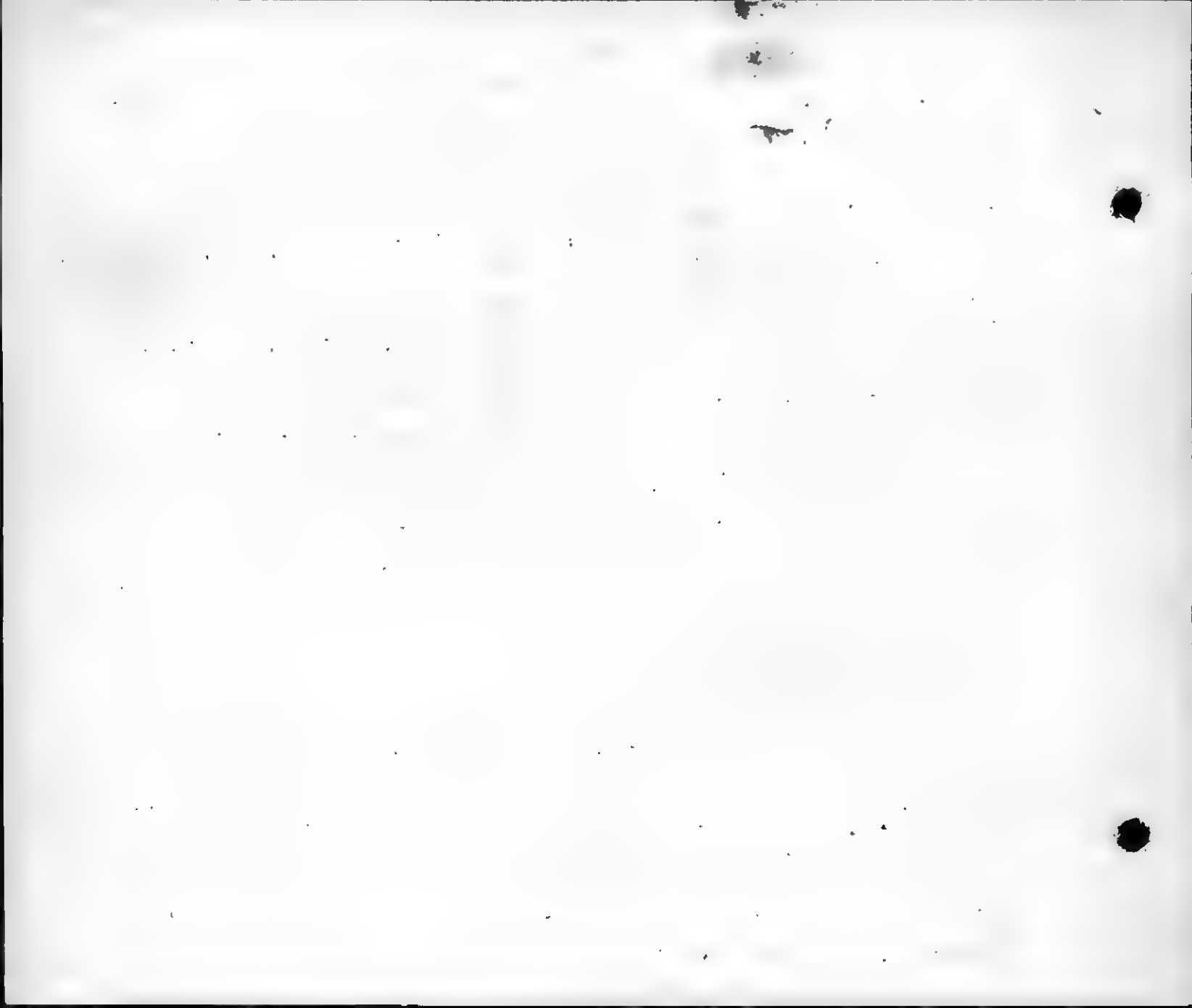
13808

13871

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7205-46th. Street		d. STREET ADDRESS 7205-46th. Street	
3. NAME OF DECEASED (Type or print) First Harry Middle Simonds Last Boteler, Jr.		4. DATE OF DEATH Month December Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-97
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months 0 Days 10	11. IF UNDER 24 HRS Hours 10 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry S. Boteler, Sr.	
14. MOTHER'S MAIDEN NAME Amelia Hess		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. WW I		17. INFORMANT Zella N. Boteler- Item #2 - Wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Myocardial Infarction DUE TO (c) Coronary Artery Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 mos. 8 mos 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2 , 19 58 to Dec 27 , 19 59 that I last saw the deceased alive on Dec 24 , 19 59 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert B. Havell		ADDRESS (Street, city or town, state) 5516 Nebraska Ave DC	
PHYSICIAN'S NAME (Type) Robert B. Havell		DATE SIGNED 12/27/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-29-59	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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13872

CERTIFICATE OF DEATH

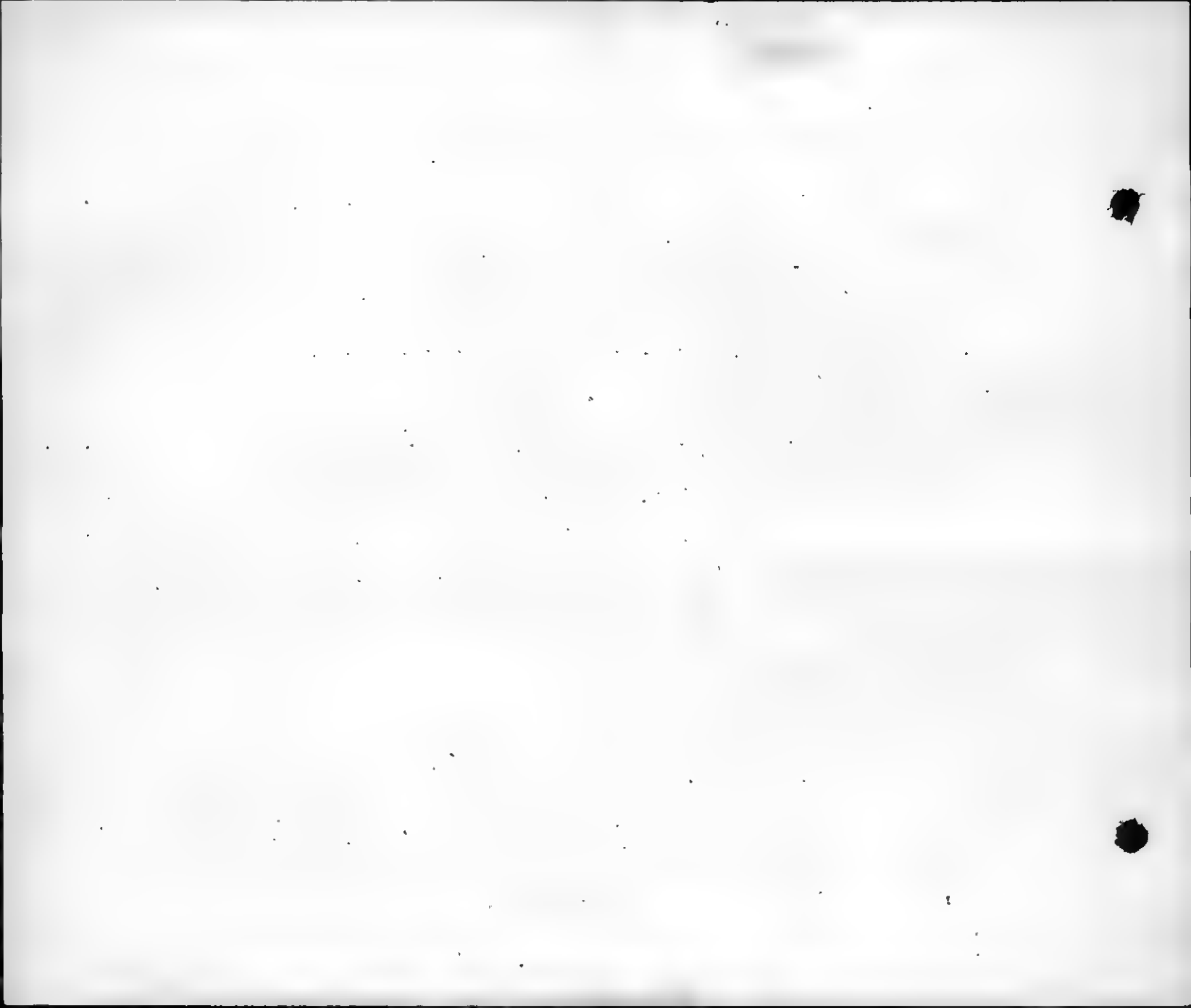
13809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Spencerville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>1 Batsen Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William G.</u> Middle <u>BOWEN</u> Last <u>BOWEN</u>				4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29, 1902</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>John Hopkins Lab.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William George Bowen</u>				14. MOTHER'S MAIDEN NAME <u>Boston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Ye-52 + 7488</u>		INFORMANT <u>Edmond Lee Bishop</u> Address <u>Emm.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 421.1 DUE TO <u>Myocardial Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Artic Insufficiency</u> (c) <u>Unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>weeks</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-15, 1959</u> , to <u>12-15, 1959</u> that I last saw the deceased alive on <u>12-15, 1959</u> and that death occurred at <u>7:20 p.m.</u> from the causes and on the date stated above.							DATE SIGNED <u>12-15-59</u>
ACTUAL SIGNATURE <u>John V. Rogers</u> M.D.				ADDRESS (Street, city or town, state) <u>1919 Lincoln Rd. 12-15-59</u>			
PHYSICIAN'S NAME (Type) <u>John V. Rogers</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE OF BURIAL <u>12/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Church</u>		22d. LOCATION (City, town, or county) (State) <u>Ashton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Anwar</u> ADDRESS <u>Rockville Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Christine E. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13878

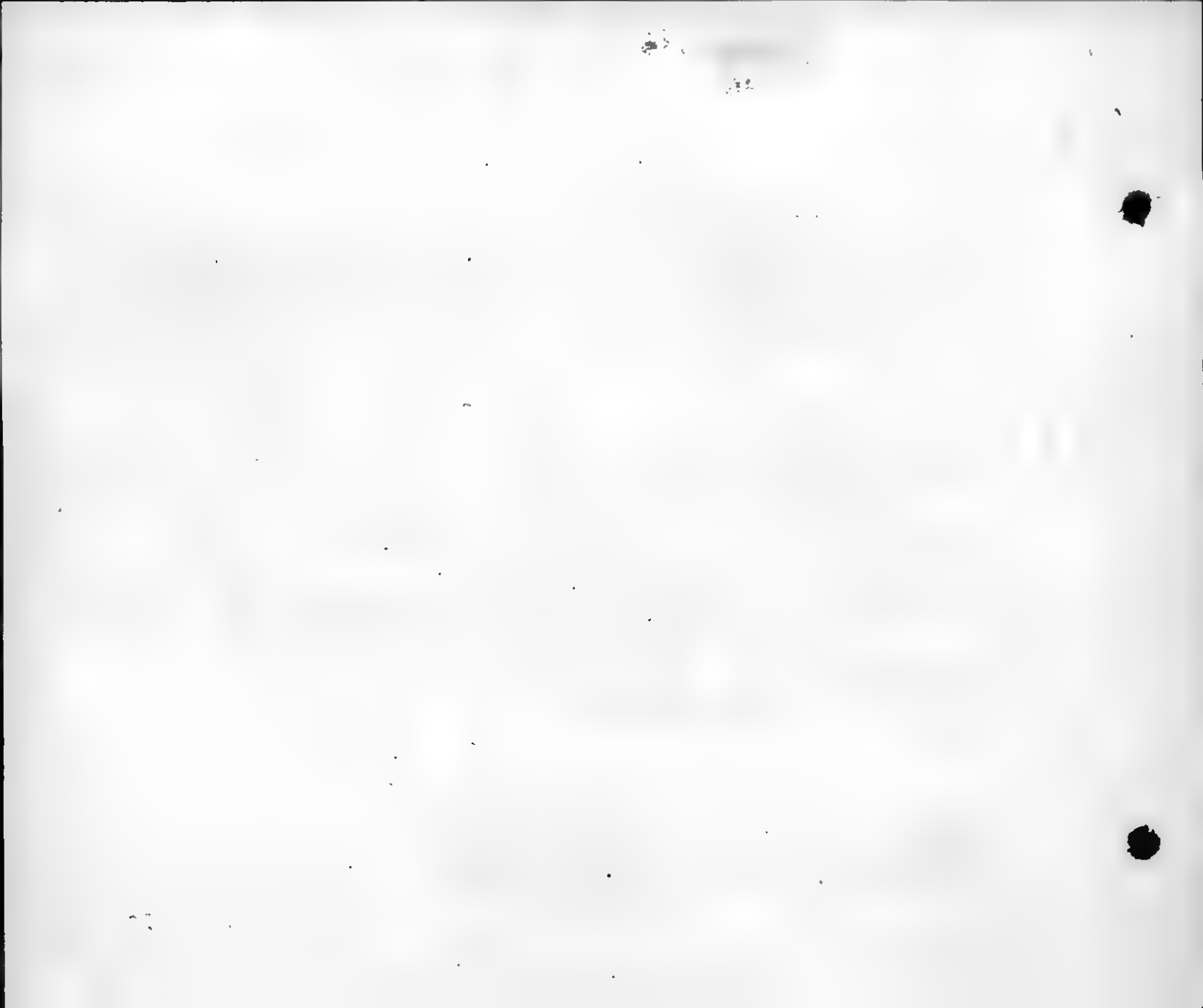
CERTIFICATE OF DEATH

Reg. Dist. No. 13810

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 49 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES ALVIN BOYER				4. DATE OF DEATH Month Day Year DECEMBER 3 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/13/89	
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Owner				10b. KIND OF BUSINESS OR INDUSTRY Farming			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WESTLY BOYER				14. MOTHER'S MAIDEN NAME Sarah C. Day			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Bronchopneumonia 491X DUE TO 2. Gastro-Intestinal Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) severe, DUE TO congenital Telangiectasia (c) 3. Urinary Retention etc. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Urinary Retention etc.							
INTERVAL BETWEEN ONSET AND DEATH 3 days 3 weeks 2 weeks							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. 15, 1957 to Dec. 3, 1957 that I last saw the deceased alive on Dec. 3, 1957 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) GAITHERSBURG, MARYLAND DATE SIGNED 12-4-57							
ACTUAL SIGNATURE J. Schumacher, M.D.							
PHYSICIAN'S NAME (Type) J. SCHUMACHER, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/6/59			
22c. NAME OF CEMETERY OR CREMATORY Darnestown				22d. LOCATION (City, town, or county) (State) Darnestown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler				24a. REC'D BY REGISTRAR DEC 7 '59			
ADDRESS Funeral Home-1331 E. Montg. Ave., Rockville, Md.				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL: The attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



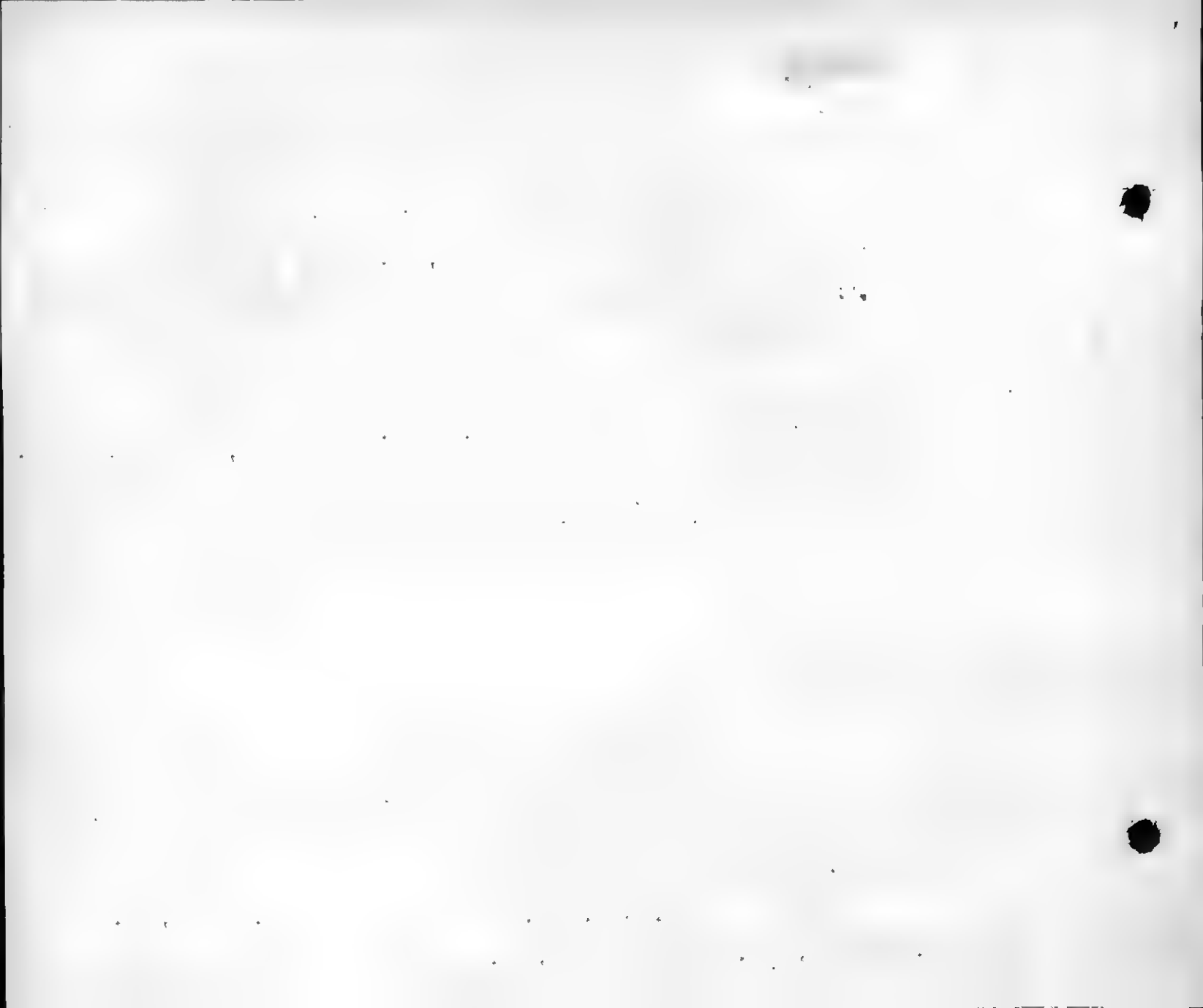
CERTIFICATE OF DEATH

Reg. Dist. No.

13811

13829

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montg. mery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>9 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium & Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. NAME OF DECEASED (Type or print) <i>Harold Lee Briggs, SR.</i>				4. DATE OF DEATH Month <i>12</i> - Day <i>17</i> Year <i>1959</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-12-07</i>	
9. AGE (In years lost birthday) <i>52 yrs.</i>		IF UNDER 1 YEAR Months <i>5</i> Days <i>2</i> Hours <i>1</i> Min.		IF UNDER 24 HRS Hours <i>1</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done most of working life, even if retired) <i>Review attorney fed. Trade Commission</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Texas</i>			
11. BIRTHPLACE (State or foreign country) <i>Texas</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Other B. Briggs</i>				14. MOTHER'S MAIDEN NAME <i>Florence Mc Millan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT <i>wife</i>				Address <i>Mrs. Ann A. Briggs 1812 Powder Mill Road, Silver Spring Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Thrombosis</i> DUE TO (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <i>19</i>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>July 15, 1956</i> to <i>Dec 17, 1959</i> that I last saw the deceased alive on <i>Dec 16, 1959</i> and that death occurred at <i>7:20 AM</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>2701 Carroll Ave</i> DATE SIGNED <i>12-17-59</i>							
ACTUAL SIGNATURE <i>James M. Whitlock M.D.</i>							
PHYSICIAN'S NAME (Type) <i>JAMES M. WHITLOCK</i>							
22a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>							
22b. DATE THEREOF <i>12/20/59</i>							
22c. NAME OF CEMETERY OR CREMATORY <i>Geo. Wash. Mem. Cemetery</i>							
22d. LOCATION (City, town, or county) (State) <i>Prince Geo. County, Md.</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i> ADDRESS <i>SILVER SPRING, MD.</i>							
24a. REC'D BY REGISTRAR <i>Raymond G. Jinks</i> DATE <i>DEC 21 '59</i>							
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							



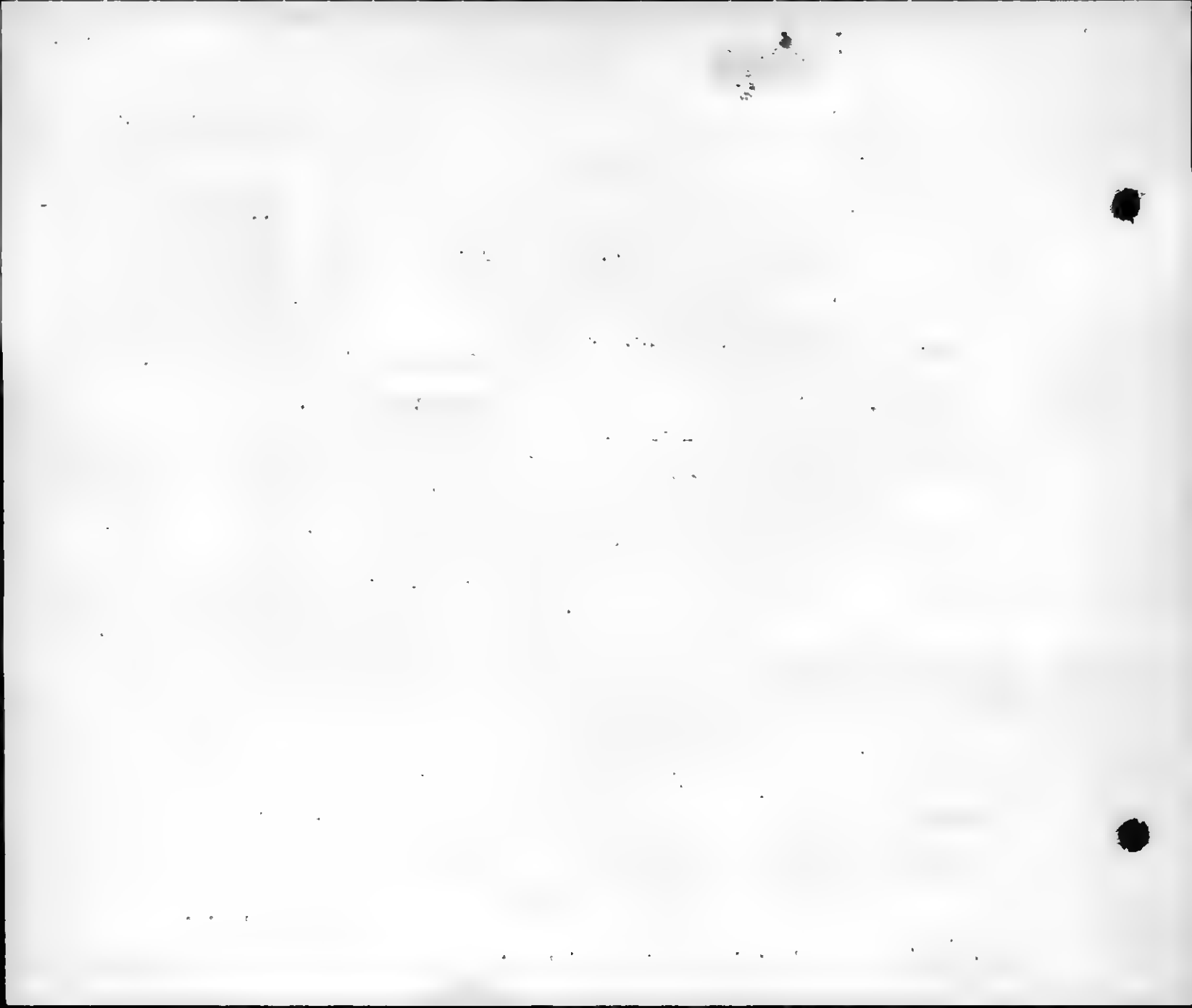
13874
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. STREET ADDRESS <u>3923 Denfeld Ave.,</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bessie June Brooke</u>				4. DATE OF DEATH Month Day Year <u>12 17 19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/86</u>		9. AGE (In years last birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Clerk (retired) U.S. Treasury</u>				11. BIRTHPLACE (State or foreign country) <u>Nebraska, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac N. Gibbs</u>				14. MOTHER'S MAIDEN NAME <u>Eva M. Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-50-6539</u>		INFORMANT <u>Son (John T. Brooke) Item #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO <u>Cerebral artery Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> (c) <u>Cerebral arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>18 Days</u> <u>18 Days</u> <u>unknown</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aneurysm circle of Willis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 30, 1957</u> , to <u>Dec 12, 1959</u> , that I last saw the deceased alive on <u>Dec 17, 1959</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10620 Georgia ave Silver Spring, Md</u> DATE SIGNED <u>Michael R. Dobridge</u>							
ACTUAL SIGNATURE <u>Michael R. Dobridge</u>		M.D. <u>10620 Georgia ave Silver Spring, Md</u>					
PHYSICIAN'S NAME (Type) <u>Michael R. Dobridge</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Liska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DEC 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13875

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Basil</u> Middle <u>Henry</u> Last <u>Buchanan</u>		4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1959</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>August 28, 1916</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Cab Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>	
11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alex Buchanan</u>		14. MOTHER'S MAIDEN NAME <u>Ewrie Angle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>233-07-6624</u>	
INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Calcific aortic dilatation</u> DUE TO (c) <u>Coronary arteriosclerosis and generalized arteriosclerosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>5-10 years</u> <u>5-10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic cholecystitis and cholelithiasis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o m <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 29, 1959</u> to <u>December 6, 1959</u> that I last saw the deceased alive on <u>December 6, 1959</u> and that death occurred at <u>7:20 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John T. Potts Jr.</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>12/6/59</u>	
PHYSICIAN'S NAME (Type) <u>John T. Potts, Jr. M.D.</u>		<u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>12/17/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ALEXANDRIA VA</u>		22d. LOCATION (City, town, or county) (State) <u>IAEGER, WEST, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.B. Mountcastle</u> <u>CUNNINGHAM FUNERAL HOME</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Orlino S. Kline</u>			

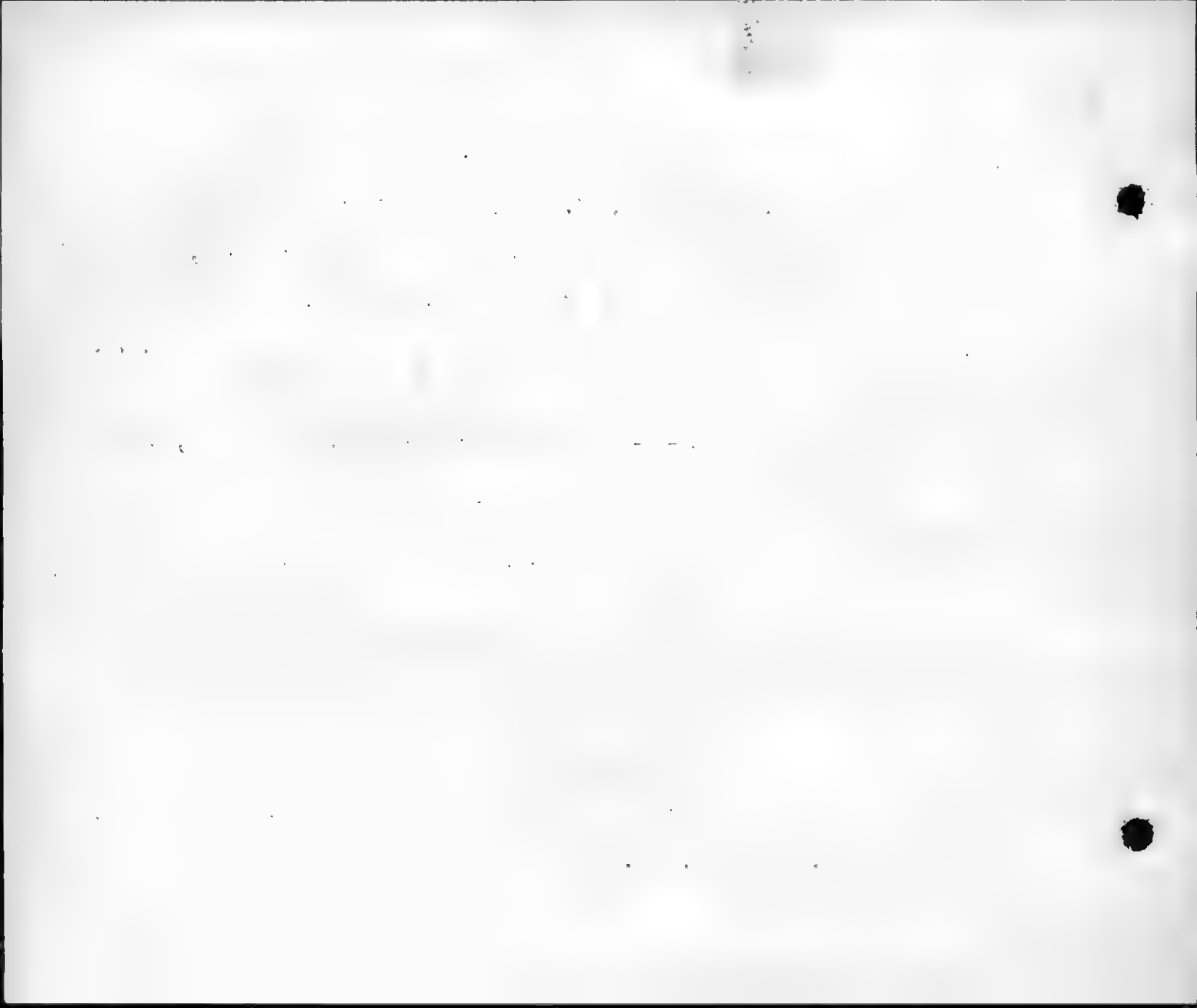
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

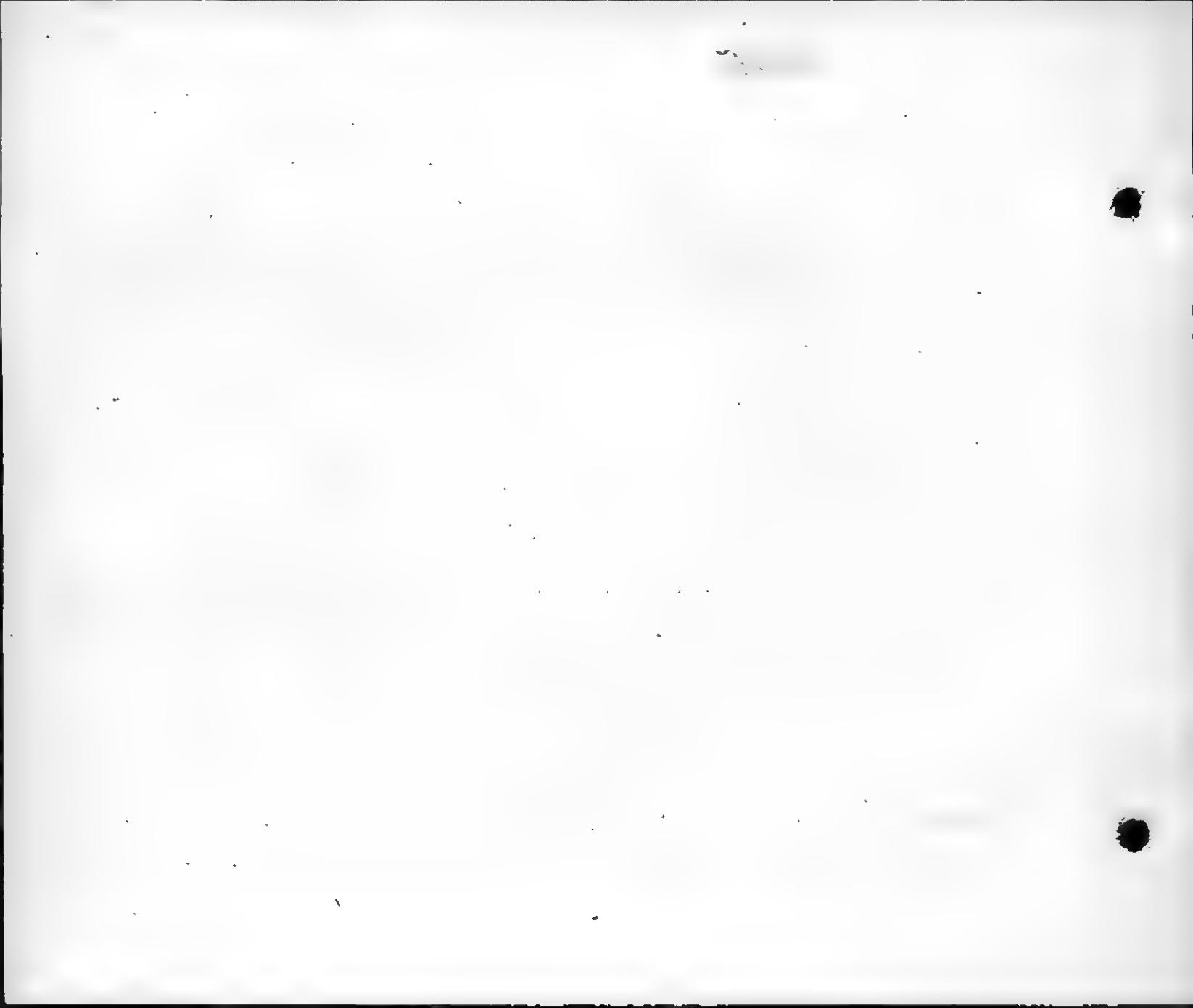
13876

CERTIFICATE OF DEATH

Reg. Dist. No.

13814

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Geo!</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenningsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>			
c. LENGTH OF STAY IN 1b <u>3-MONS</u>				d. STREET ADDRESS <u>#5-Horseshoe Rd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall - Sant.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>A.</u> Last <u>CADELL</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14 1885</u>	
9. AGE (In years lost birth day) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>		11. AGE (In years lost birth day) <u>74</u> yrs.		12. IF UNDER 24 HRS Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Phil. Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John McKay</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. Mc Elhatton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				18. INFORMANT <u>Agnes B. Luskey</u> Address <u>#5-Horseshoe Rd Clinton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>SEPT. 12, 1959</u> , to <u>DEC. 30, 1959</u> , that I last saw the deceased alive on <u>DEC. 30, 1959</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William J. Bowden</u> M.D. <u>5206 Norway Dr</u> <u>12-30-59</u>							
PHYSICIAN'S NAME (Type) <u>Clayton C. Bowden</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>1-2-1960</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl</u>							
22d. LOCATION (City, town, or county) (State) <u>Clinton Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ammons Bros</u> ADDRESS <u>1661-Grand Hope Rd SE WASH. 20 DC</u>							
24a. REC'D BY REGISTRAR <u>DEC 31 '59</u>							
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>							



13830 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 13815

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Schirmer Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 10112 Pierce Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Joseph Middle Campbell Last 4. DATE OF DEATH Dec. 15 1959 Month Dec. Day 15 Year 1959		5. SEX Male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10-11-82 9. AGE (In years last birthday) 77 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Plate Printer 11. BIRTHPLACE (State or foreign country) Distriet of Columbia 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Campbell 14. MOTHER'S MAIDEN NAME Catherine Cloney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Old Records in Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 11, 1959 to Dec. 15, 1959 , that I last saw the deceased alive on Dec. 14, 1959 , and that death occurred at 7:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10111 Celesville Rd. DATE SIGNED G. F. Thibadeau ACTUAL SIGNATURE G. F. Thibadeau M.D. 10111 Celesville Rd. PHYSICIAN'S NAME (Type) A. F. Thibadeau Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 12/17/59 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 22d. LOCATION (City, town, or county) (State) Washington, D.C.		23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Heils Co. - 2901 14th St N.W. D.C. ADDRESS Washington, D.C. 24a. REC'D BY REGISTRAR DEC 17 1959 24b. REGISTRAR'S SIGNATURE John S. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG254 1-4-60 et

13831

CERTIFICATE OF DEATH

Reg. Dist. No. 13816

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		d. STREET ADDRESS 7516 CARROLL AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7516 CARROLL AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First Middle Last		4. DATE OF DEATH DEC. 26, 1959. Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 17, 1882
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME MARTIN CHAMBERS		14. MOTHER'S MAIDEN NAME CATHERINE NOLAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MR JAMES CANAVAN, 7516 CARROLL AVE., MD.		Address TAKOMA PARK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APR 1946 to 26 DEC 1959 , that I last saw the deceased alive on 26 DEC 1959 , and that death occurred at 1045 M, from the causes and on the date stated above			
ACTUAL SIGNATURE H. B. QUEEN		ADDRESS (Street, city or town, state) 7112 WILLOW AVE DATE SIGNED 26 DEC 1959	
PHYSICIAN'S NAME (Type) H. B. QUEEN		TAKOMA PARK MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC 1959	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) BLADENSBURG, PR GEO. CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS 254 CARROLL ST. N.W., D.C.		24a. REC'D BY REGISTRAR DEC 30 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

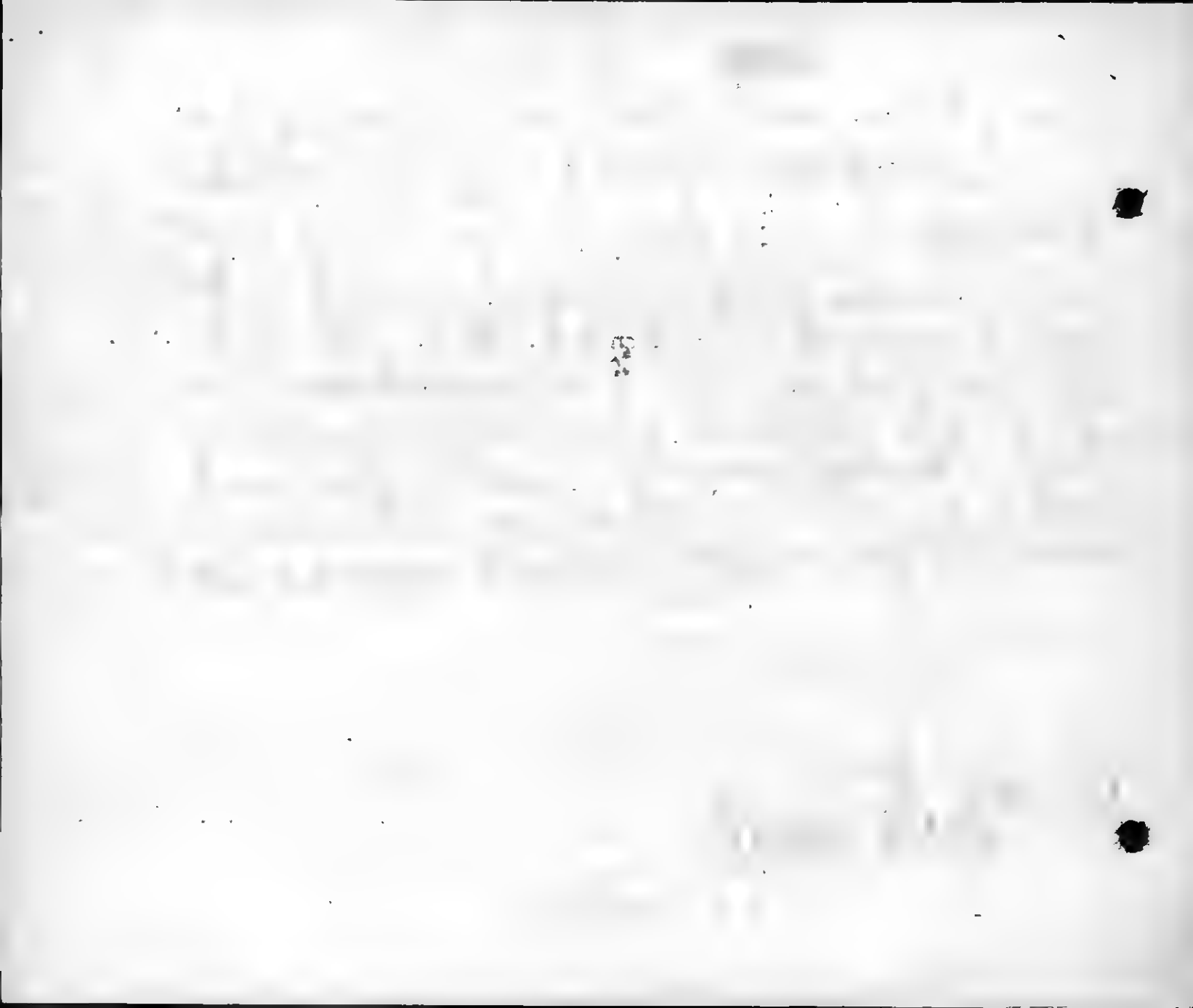
13877

CERTIFICATE OF DEATH

Reg. Dist. No. **13817**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Chevy Chase 10 Years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4710 Hunt Ave.				e. STREET ADDRESS 4710 Hunt Ave.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLARK E. CARRIER				4. DATE OF DEATH Month Day Year Dec. 27, 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1903	
9. AGE (In years last birthday) yrs 56		10. IF UNDER 1 YEAR Months Days 4 24		11. IF UNDER 24 HRS Hours Min 4 24		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Stohlman Chev.		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME Albert Carrier				14. MOTHER'S MAIDEN NAME Pearl Kunselman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 578-05-6311		INFORMANT Address Oma Carrier - Item #2 - Wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Disease DUE TO (c) 17 years +							INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 1942	
21. I certify that I attended the deceased from 1942, 19 to 12/27, 1959 that I last saw the deceased alive on 12/27, 1959, and that death occurred at 7:10 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>William P. Argy</i> M.D.				ADDRESS (Street, city or town, state) 1150 Conn. Ave., N.W.			
PHYSICIAN'S NAME (Type) WILLIAM P. ARGY				DATE SIGNED Over			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				ADDRESS Washington, D. C.		24a. REC'D BY REGISTRAR DEC 30 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13818
13878										13818
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>26</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>1310 North Van Buren</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>BABY GIRL CARROLL</u>					4. DATE OF DEATH <u>DECEMBER 27</u> 19 <u>59</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/27/59</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>5</u> Days <u>50</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PAUL EDWARD CARROLL</u>					14. MOTHER'S MAIDEN NAME <u>IDA MAE GENIES</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>					16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>MOTHER</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atelectasis</u> DUE TO <u>Immature premature</u> (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>12</u> Day <u>27</u> Year <u>19</u> Hour <u>—</u> o. m. <u>—</u> p. m. <u>—</u>			20d. INJURY OCCURRED White <input type="checkbox"/> at work <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/27</u> , 19 <u>59</u> to <u>12/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>59</u> , and that death occurred at <u>11:40</u> M. from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>W. F. Colleton, Jr.</u> M.D.					ADDRESS (Street, city or town, state) <u>809 Kern Mill Rd Rockville, Md</u> DATE SIGNED <u>12/29/59</u>					
PHYSICIAN'S NAME (Type) <u>William F Colleton Jr MD</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>			22b. DATE THEREOF <u>12-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>800 Old Georgetown Rd Bethesda Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital-800 Old Georgetown Rd</u>					ADDRESS <u>Bethesda Md</u>		24a. REC'D BY REGISTRAR <u>12-29-59</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

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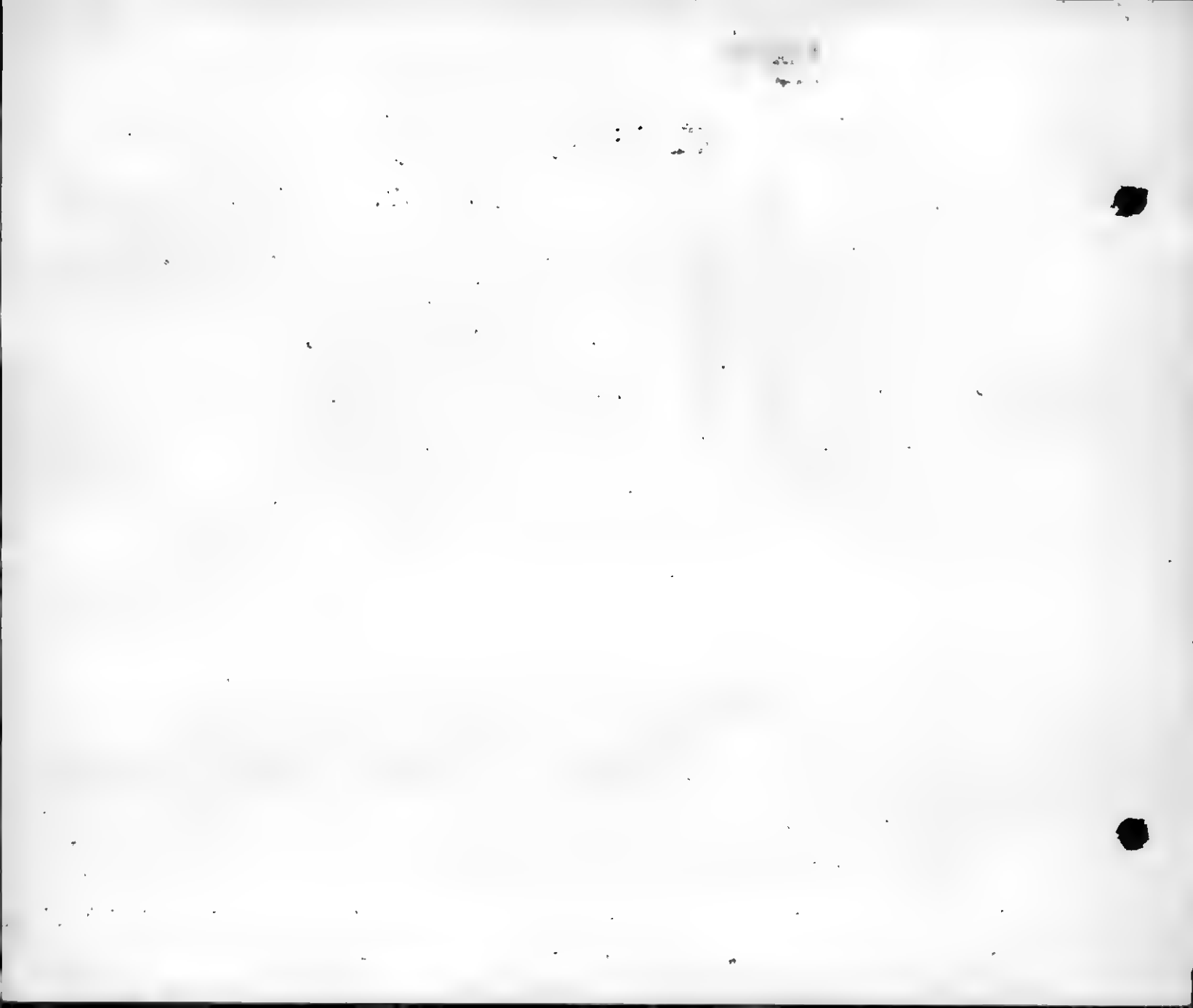
21.7.

X V O

Bethesda Md

DEC 31 1959

Carlton S. Kline



TO DEPUTY REGISTRAR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13819

13879

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairthursburg</i>		c. LENGTH OF STAY IN 1b <i>life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>RFD</i>		d. STREET ADDRESS <i>R-1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Paul</i> Last <i>Caulfield</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>28</i> Year <i>1957</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-22-1902</i>
9. AGE (In years last birthday) <i>57</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>md.</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>WM S. Caulfield</i>		14. MOTHER'S MAIDEN NAME <i>Eliz. Hunter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i></i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Helen C. Madine (daughter)</i>		Address <i>Stin 2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i></i> INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pulmonary Tuberculosis 2 yrs (arrested)</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschert</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-30-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Rose</i>		22d. LOCATION (City, town, or county) (State) <i>St. Rose Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest G. Jantner, Fairthursburg Md.</i>		24a. REC'D BY REGISTRAR DATE DEC 30 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



CERTIFICATE OF DEATH

Reg. Dist. No.

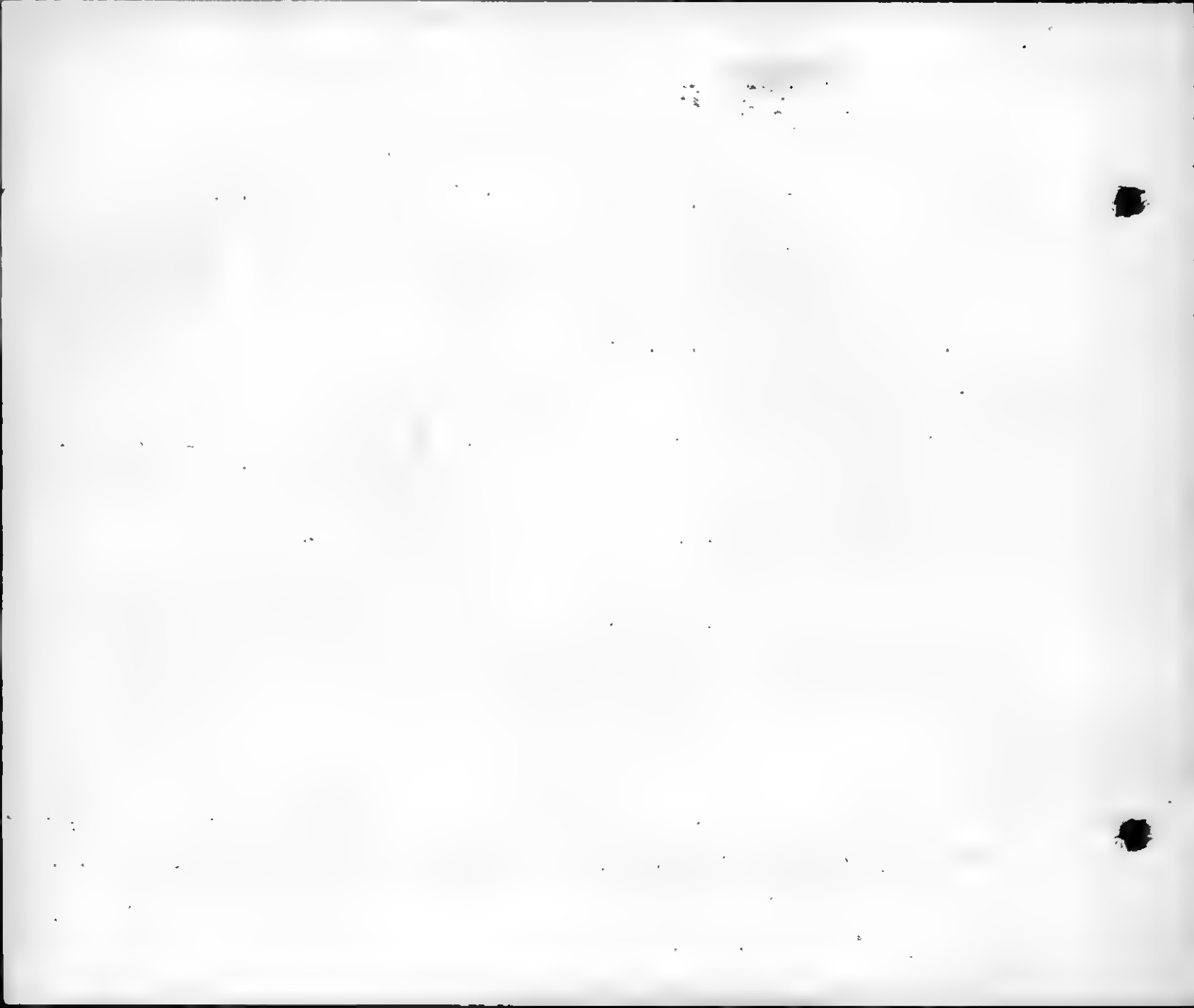
13820

13880

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1800 GRACE CHURCH RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle W. Last CHASE		4. DATE OF DEATH Month Dec. Day 5, Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/30/1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REI. ARCHITECT		10b. KIND OF BUSINESS OR INDUSTRY U. S. NAVY	
11. BIRTHPLACE (State or foreign country) COLORADO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME REV. DEMPSTER W. CHASE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
INFORMANT STANHOPE CHASE		Address 4844 CHAIN BRIDGE RD. McLEAN, VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) enlarged prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10, 1957 , to Dec 5, 1959 , that I last saw the deceased alive on 12/5, 1959 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPH Markwood M.D. 3208 - 17th St. N.W. Wash. D.C. 12/5/59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) E.H. Markwood, M.D. 3208 17th St., N.W., WASH., D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/8/59	
22c. NAME OF CEMETERY OR CREMATORY HOLLYWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) RICHMONT, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph H. Markwood		24a. REC'D BY REGISTRAR DATE DEC 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. ADDRESS 1756 PA. AVE., N.W.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13881

CERTIFICATE OF DEATH

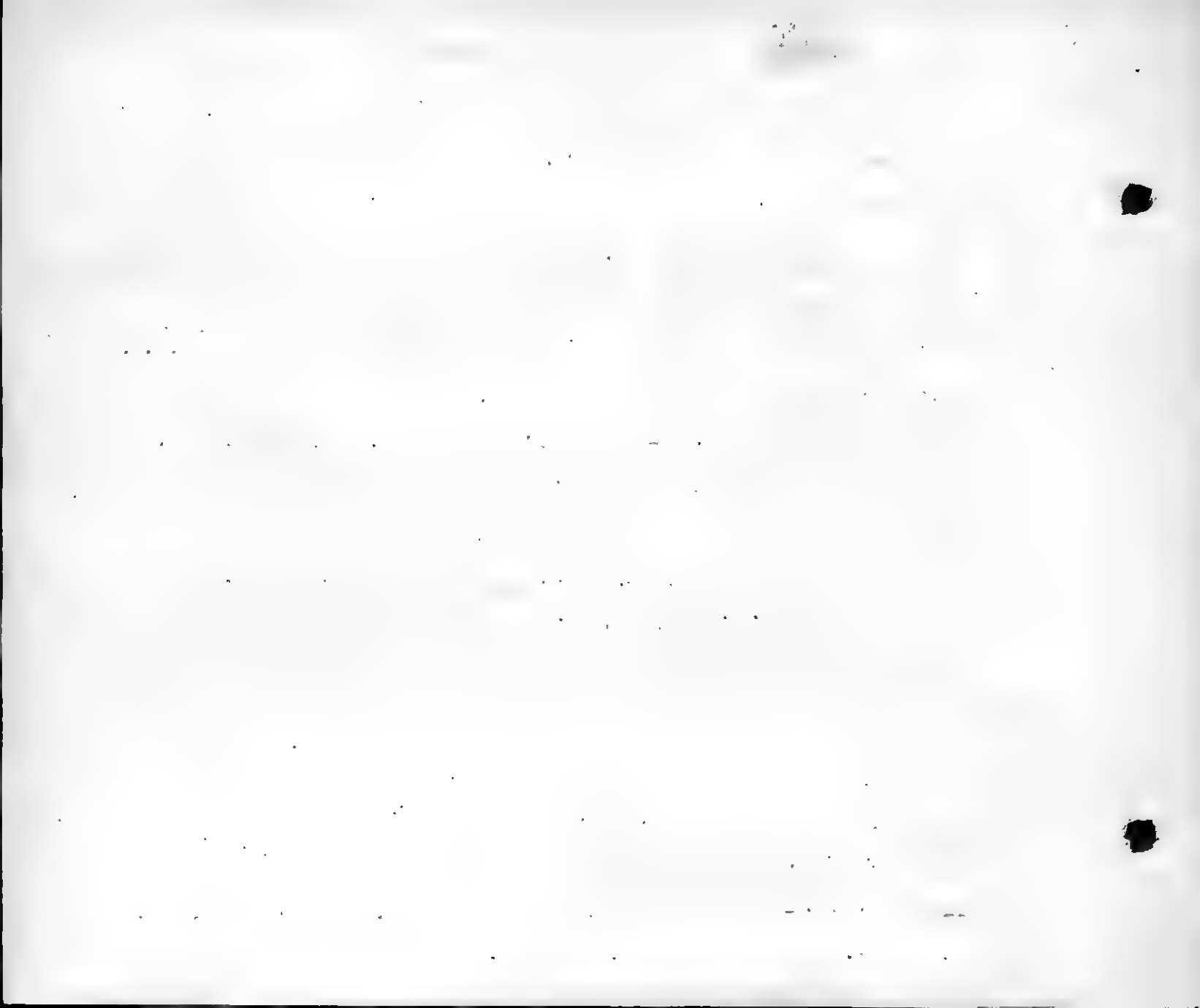
Reg. Dist. No.

13821

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 8 days 6 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vasilios Middle I. Last Chebithes		4. DATE OF DEATH Month 12 Day 10 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Self employed	11. BIRTHPLACE (State or foreign country) Greece
13. FATHER'S NAME Isadore Chebithes		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 290-18-2363	
17. ADDRESS Julia Sapounakis, 4813 Bayard Blvd. Bethesda Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IRREVERSIBLE SHOCK & TOXEMIA 578x DUE TO Massive ABDOMINAL ABSCESS; Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO Perforated appendix, Intestinal obstruction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) atelectasis, Lungs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 12-1-1959 to 12-10-1959 , that I last saw the deceased alive on 12-9-59 , 19 _____, and that death occurred at 12:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Linwood H. Johnson M.D.		ADDRESS (Street, city or town, state) 4630 Montecore Ave, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Linwood H. Johnson		DATE SIGNED 12-12-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-14-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR DEC 14 '59	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. K...	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG254 1-22-60 et

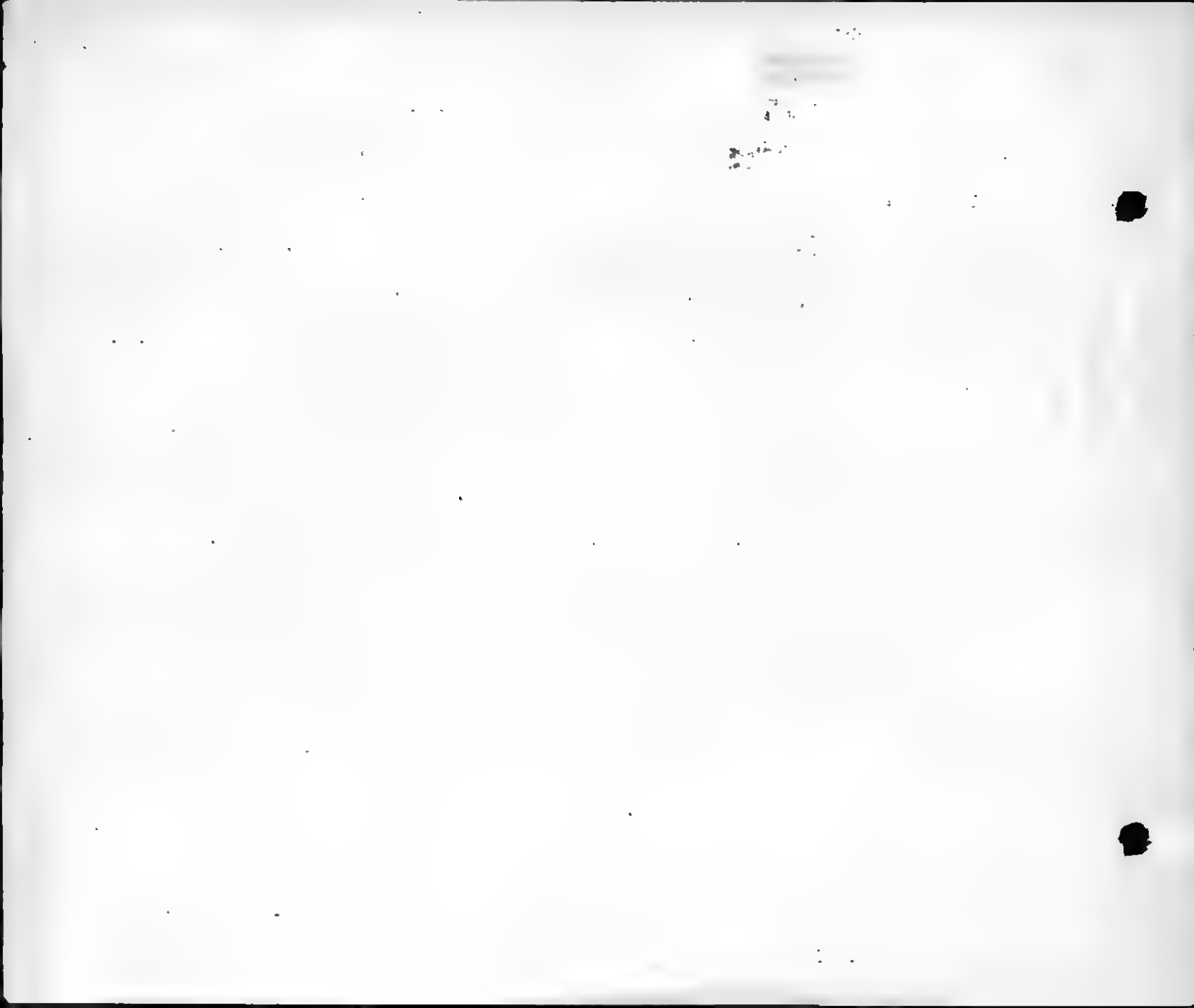
CERTIFICATE OF DEATH

Reg. Dist. No.

13822

13882

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D.C. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5424 Nebraska Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SOPHIE Middle C Last CLARK		4. DATE OF DEATH Month DECEMBER Day 14 Year 1959	
5. SEX Female	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1871 Nov. 14, 1869
9. AGE (In years last birthday) 88 1/2 yrs		10. IF UNDER 1 YEAR Months 1 Days 14 Hours 19 Min. 59	11. IF UNDER 24 HRS Months 1 Days 14 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Clagett		14. MOTHER'S MAIDEN NAME Elizabeth Eicher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Elizabeth Clark -5424 Neb Ave Wash. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from DEC. 7, 1959 to DEC. 14, 1959 , that I last saw the deceased alive on DEC. 14, 1959 , and that death occurred at 10:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry Lowden		ADDRESS (Street, city or town, state) 5206 Norway Dr. 12/14/59	
PHYSICIAN'S NAME (Type) Henry Lowden		DATE SIGNED 12/14/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12-17-59	22c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Jones		ADDRESS Wash. D.C.	
24a. REC'D BY REGISTRAR DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13823

13857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1607 Blanford Ave - apt 3</u>				d. STREET ADDRESS <u>1607 Blanford Ave - apt 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willis Court Clem</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-5-1913</u>	
9. AGE (In years last birthday) <u>46 yrs</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>air conditioning</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N. I. H.</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
13. FATHER'S NAME <u>Adrian E. Clem</u>				14. MOTHER'S MAIDEN NAME <u>Annice Lloyd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>14-11-11</u>		17. INFORMANT <u>Virginia Clem (wif)</u> Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary occlusions</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>12-14-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>12/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset</u>		22d. LOCATION (City, town, or county) (State) <u>Christiansburg, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> <u>1331 E. Montg. Ave., Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No.

13824

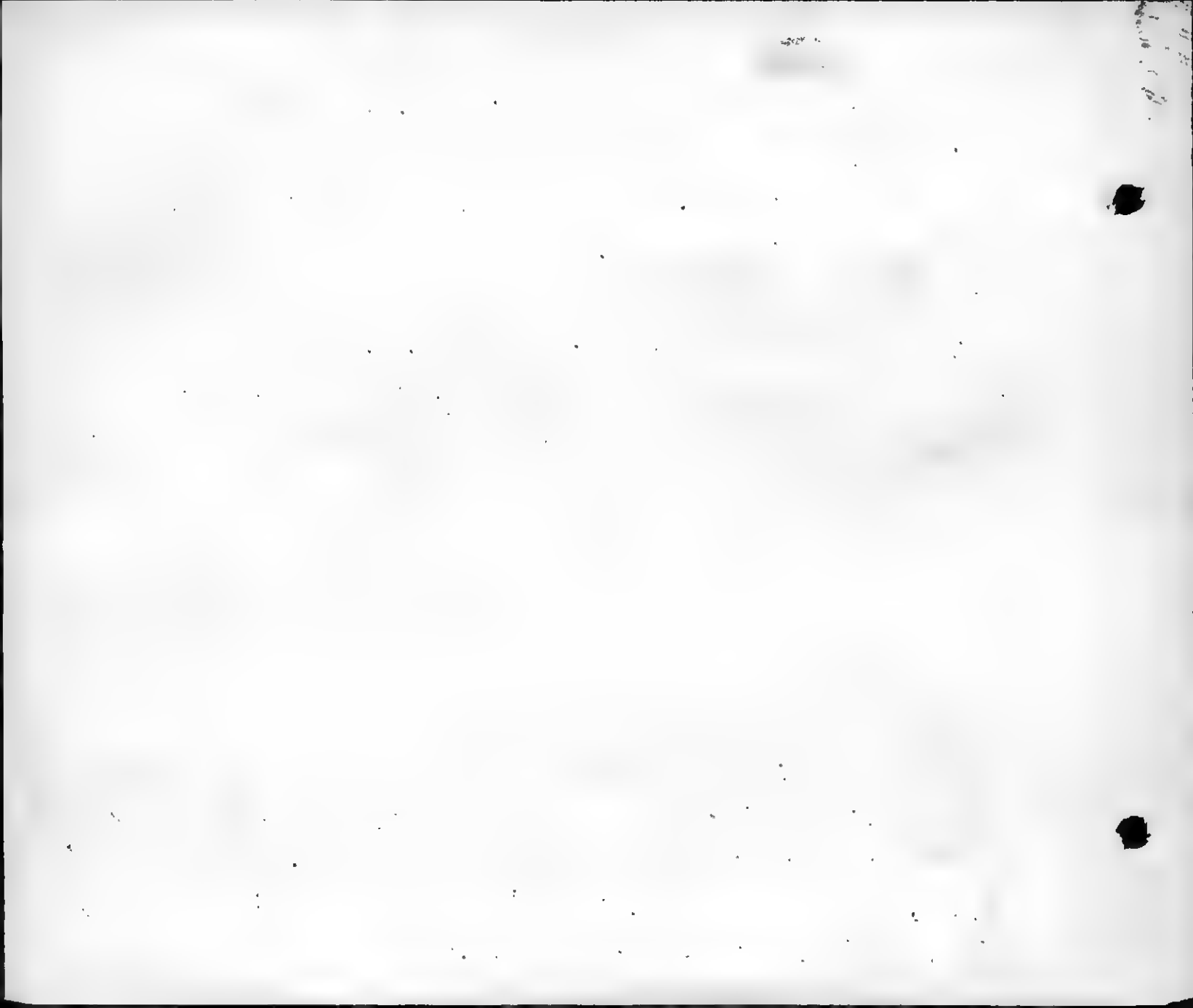
13883

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. COUNTY <u>MONTGOMERY</u> STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WHEATON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>12004 CENTER HILL STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY LOUISE Collins</u>		4. DATE OF DEATH Month Day Year <u>12 5 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-1922</u>
9. AGE (In years last birthday) <u>37</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOMEMAKER</u>	
11. BIRTHPLACE (State or foreign country) <u>DISTRICT OF Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT E. PRESTLE</u>		14. MOTHER'S MAIDEN NAME <u>MARY ADALADE NASH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mr. Francis Collins SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF OVARY</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>APPROX. 8 WKS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>ABOUT OCT. 15 1959</u> to <u>DEC. 5, 1959</u> , that I last saw the deceased alive on <u>DEC. 5, 1959</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Tuohy</u>		ADDRESS (Street, city or town, state) <u>7720 Wisconsin Ave. Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN H. TUOHY</u>		DATE SIGNED <u>12/5/59</u>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-9-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>		24a. REC'D BY REGISTRAR <u>DEC 7 '59</u>	
ADDRESS <u>3821 14th St. N.W., Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13825

HOSP. COPY

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 hrs. 45 mins. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 4810 Leland Street	
3. NAME OF DECEASED (Type or print) John A. Corbin		4. DATE OF DEATH Month Dec. Day 11 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/96
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 11 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Chicago, Ill		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Francis Corbin		14. MOTHER'S MAIDEN NAME Mary Gallagher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1	
17. INFORMANT Wife		Address Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aneurysm of ant. cerebral artery 9040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 11 days DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell at home 10-31-59 and struck forehead on concrete floor			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 2 a. m. 10-11 19 59 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Chevy Chase Md (County) mtg (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 12-11-59	
EXAMINER'S NAME (Type) FRANK J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/14/59	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	22d. LOCATION (City, town, or county) Silver Spring, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



13884

MEDICAL CERTIFICATION

VS. A15ME(S)
SM 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

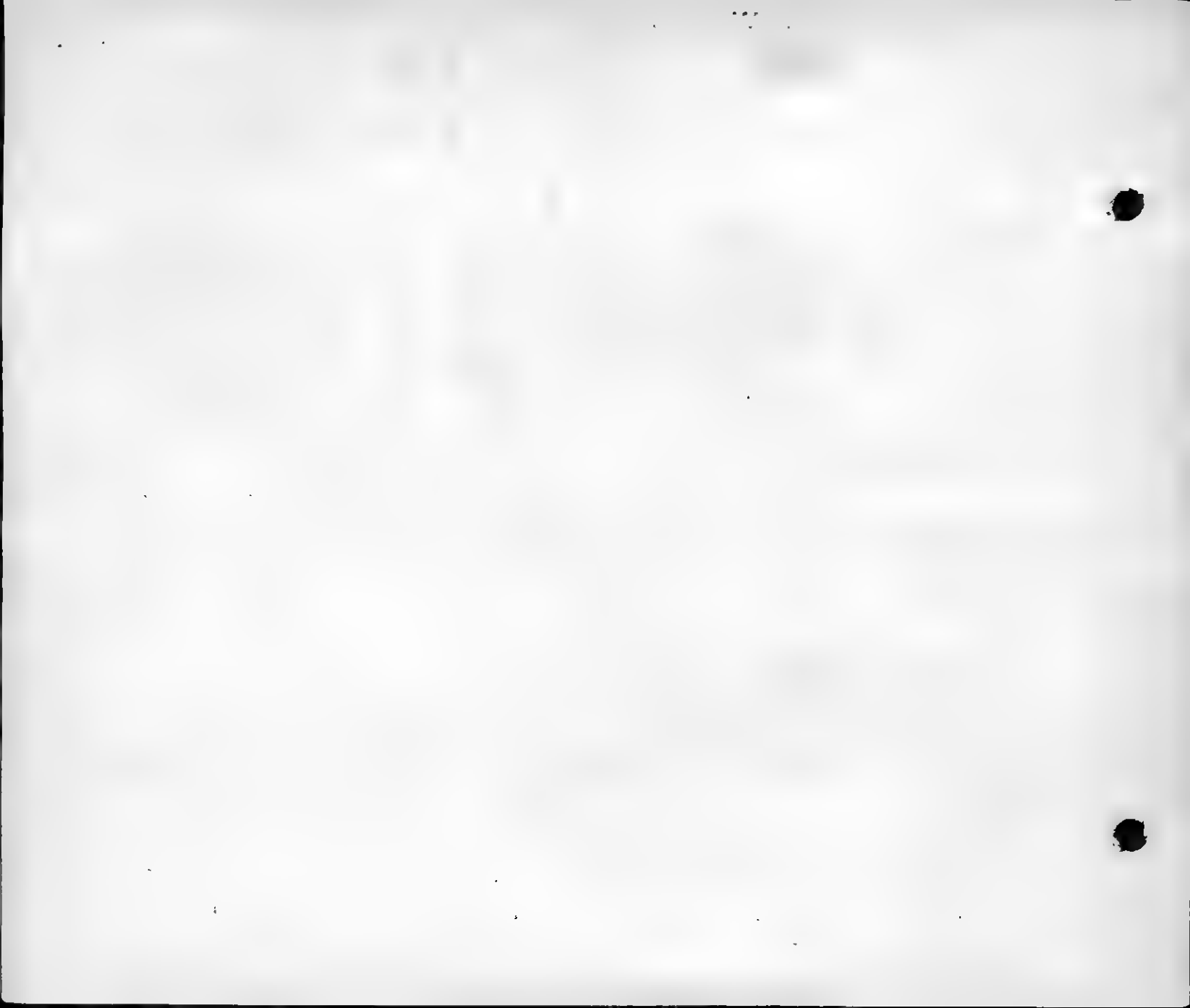
13886

CERTIFICATE OF DEATH

13827

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>34 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>10601 Nash Place</u>			d. STREET ADDRESS <u>10601 Nash Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>JULIAN</u> Middle <u>SMITH</u> Last <u>COTTRELL</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1899</u>		9. AGE (In years lost birthday) <u>60</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond, Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME <u>Julian S. Cottrell</u>		
14. MOTHER'S MAIDEN NAME <u>Eva Anderson</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>(Rev. no. or unknown)</u>			17. INFORMANT <u>Mrs Evelyn C. Cottrell, (Same as #2)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bronchus</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>16 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>10/20/59</u> 19 to <u>12/1/59</u> 19, that I last saw the deceased alive on <u>12/1/59</u> 19, and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Julius J. Curry M.D.</u>			ADDRESS (Street, city or town, state) <u>10620 Georgia Ave</u>		
PHYSICIAN'S NAME (Type) <u>Julius J. Curry</u>			DATE SIGNED <u>12/1/59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec. 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Spring Rd</u>	
22d. LOCATION (City, town, or county) <u>Prince George Co.</u>		22e. (State) <u>Md.</u>		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>			ADDRESS <u>254 Carroll St NW DC</u>		
24a. REC'D BY REGISTRAR <u>DEC 3 '59</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

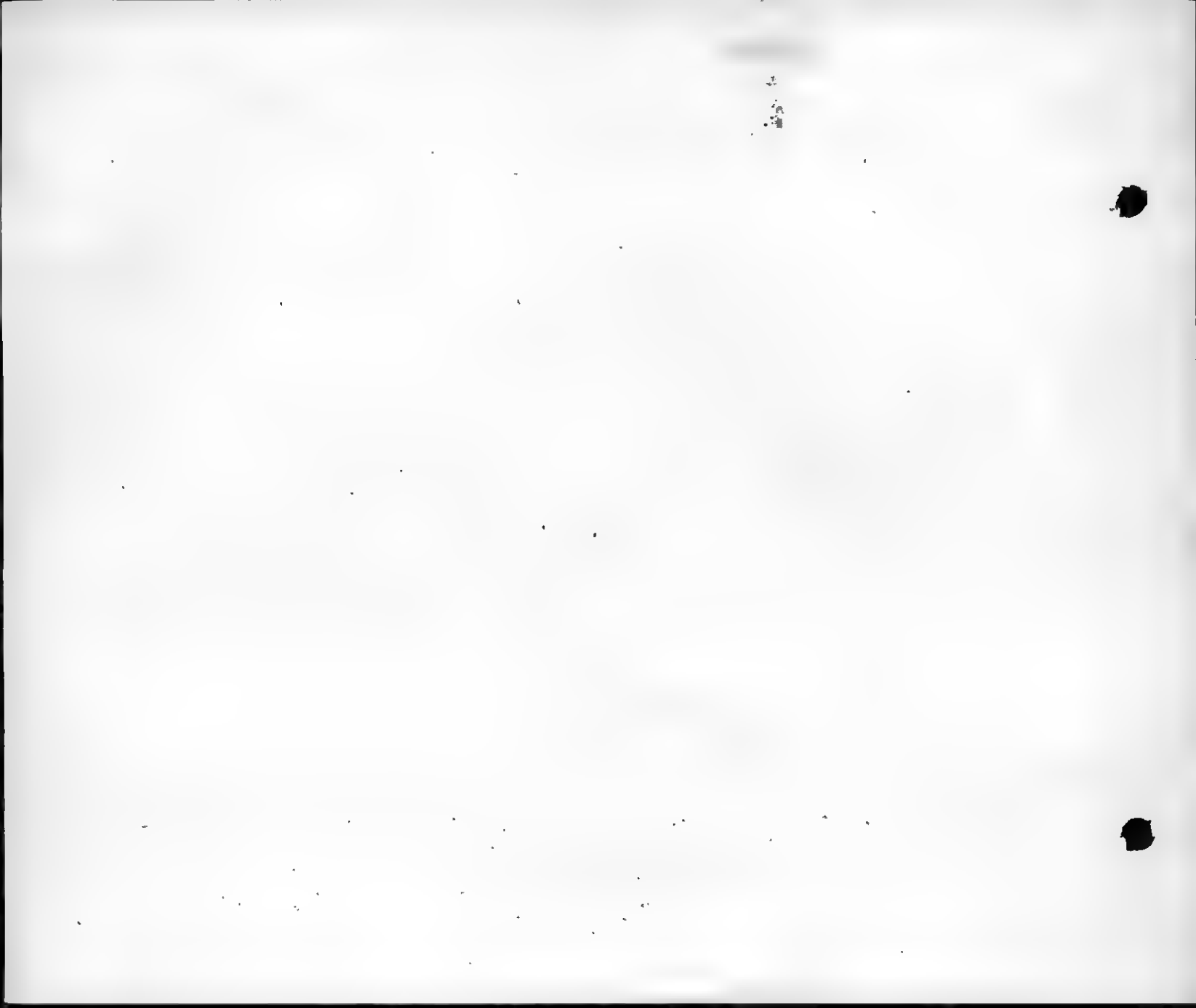
Item 8 Film G253 12-23-59 et

13887

CERTIFICATE OF DEATH

Reg. Dist. No. 13828

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>3 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8628 PINEY BRANCH ROAD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MARYLAND</u>	
d. STREET ADDRESS <u>18628 PINEY BRANCH ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>MARY</u> Last <u>CRONIN</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASOID</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u> <u>SEPT. 27, 1882</u>
9 AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11 BIRTHPLACE (State or foreign country) <u>IRELAND</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MICHAEL REARDON</u>	
14. MOTHER'S MAIDEN NAME <u>MARY Foley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>MISS MARGARET CRONIN 8628 PINEY BRANCH RD.</u>		17. INFORMANT <u>MISS MARGARET CRONIN 8628 PINEY BRANCH RD.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>462.1</u> DUE TO <u>CARDIOVASCULAR COLLAPSE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HEMORRHAGE -</u> DUE TO (c) <u>ESOPHAGEAL VARICES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>6 HOURS</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEPATIC CIRRHOSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>55</u> , to <u>DEC. 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>DEC. 11</u> , 19 <u>59</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph D. Connor, M.D.</u>		ADDRESS (Street, city or town, state) <u>9420 OLD GEORGETOWN RD.</u> DATE SIGNED <u>DEC 11, 1959</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR, M.D.</u>		<u>BETHESDA 14, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12/13/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>St. Mary's, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Huntington</u>		ADDRESS <u>5732</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		DATE <u>DEC 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13823

Reg. Dist. No.

13888

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5835 Conway Road				d. STREET ADDRESS 5835 Conway Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Clarence Middle A Last Crowe				4. DATE OF DEATH Month Dec. Day 8 Year 19 59									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1908		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 6 Days 12		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Military Planning				10b. KIND OF BUSINESS OR INDUSTRY Officer USA				11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Crowe						14. MOTHER'S MAIDEN NAME Louella Reep							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW II				16. SOCIAL SECURITY NO. 555-40-8479				17. INFORMANT Irene Crowe-wife-same as 2d					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) in bed DUE TO (c) Found dead </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 									
20c. TIME OF INJURY Hour 19 a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County) 		(State) 	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.													
ACTUAL SIGNATURE Frank J. Broschart						DATE SIGNED 12/8/59							
EXAMINER'S NAME (Type) Frank J. Broschart						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-11-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National				22d. LOCATION (City, town, or county) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY						24a. REC'D BY REGISTRAR DEC 10 '59						24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13889

CERTIFICATE OF DEATH

13831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MORCAS REBECCA DAVIS		4. DATE OF DEATH Month Day Year DECEMBER 25 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2 1885
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME -- Hiram Nesselrodt		14. MOTHER'S MAIDEN NAME REBECCA K. --	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myoplavin, peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypertensive cardiac disease DUE TO (c) 10 yrs			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 25 , 19 59 , to Dec 25 , 19 59 , that I last saw the deceased alive on Dec 25 , 19 59 , and that death occurred at 5:55 P. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sandy Spring Md 12/26/59			
ACTUAL SIGNATURE A. D. Bonifant		M.D. Sandy Spring Md	
PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		SANDY SPRING, MARYLAND	
22a. BURIAL, CREMATORY, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 28 59	22c. NAME OF CEMETERY OR CREMATORY Flower Hill	22d. LOCATION (City, town or county) (State) Redland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ray W Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR DATE DEC 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, this funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13832

13890

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>3 mo 5 dn</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Howard</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Friendship</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Edward Day</u>			4. DATE OF DEATH Month Day Year <u>Dec 5 1959</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>March 29 1975</u>		9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>James Day</u>					
14. MOTHER'S MAIDEN NAME <u>Martha Parsley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>West Friendship, Howard Co., Md.</u> <u>Mary Mullinix</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>690.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tuberculosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21. I certify that I attended the deceased from <u>12/4</u> , 19 <u>59</u> , to <u>12/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>59</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>12/6/59</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>C. H. Higinbotham MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>			
22d. LOCATION (City, town, or county) <u>Alpha, Md</u>		22e. (State) _____					
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>			24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>				
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>			_____				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shows, be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13891

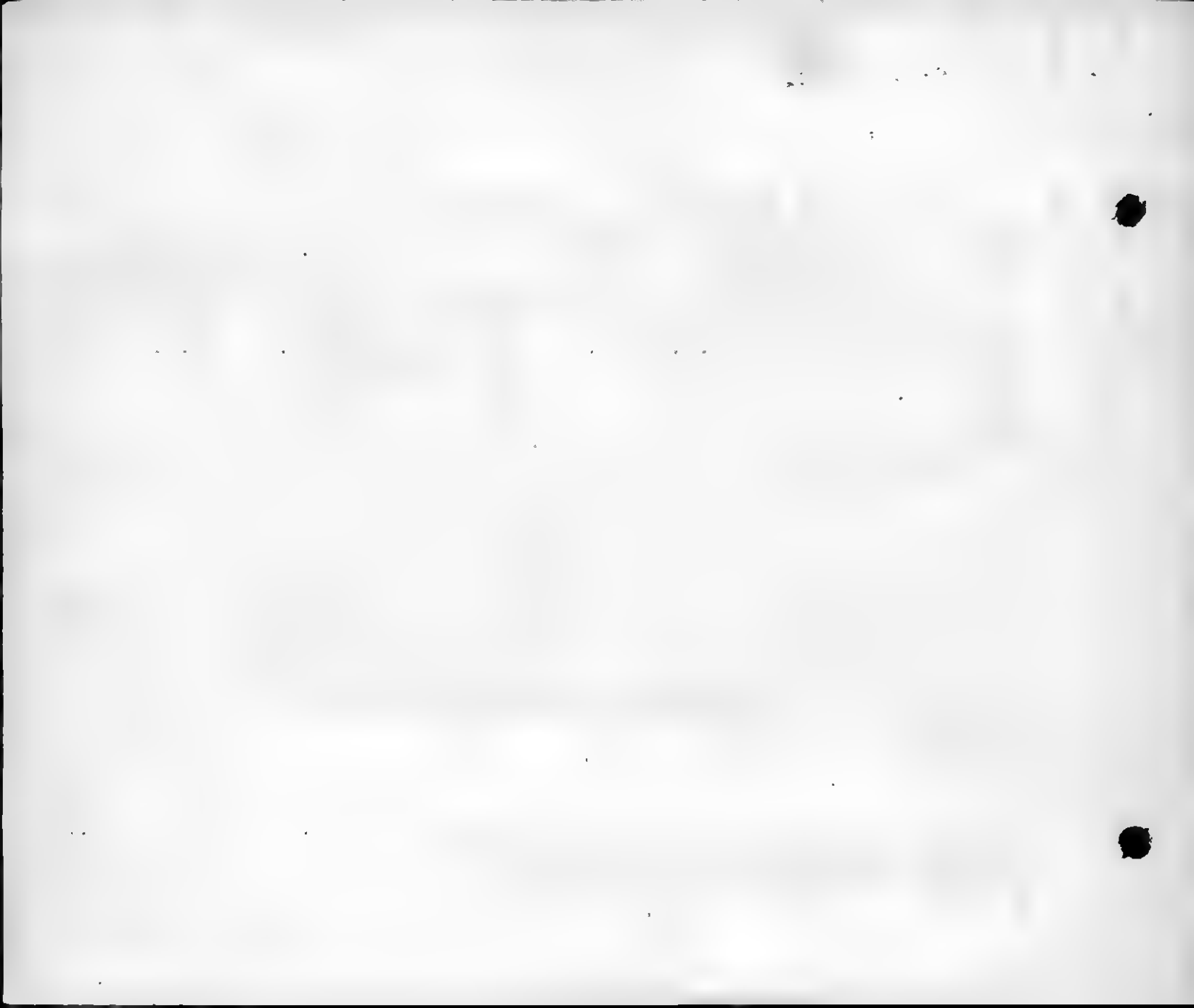
CERTIFICATE OF DEATH

Reg. Dist. No.

13833

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 9 years		d. STREET ADDRESS 4840 Bayard Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4840 Bayard Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAURA MAE DECKER		4. DATE OF DEATH Month December Day 22 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 28, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Month 10 Day 24	11. IF UNDER 24 HRS Hours 10 Min 24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James B. Burch		14. MOTHER'S MAIDEN NAME Lillian Colton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Harold Ham-Item #2- Daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH less than hour years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Dec. 28, 1959 to present , that I last saw the deceased alive on Dec. 22, 1959 , and that death occurred at 3:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. P. Ryland		ADDRESS (Street, city or town, state) 4400 - 49th St. N.W. Washington 16, D.C.	
PHYSICIAN'S NAME (Type) C. P. RYLAND		DATE SIGNED 12-22-59	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF 12-24-59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13834

13892

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12,502 FELDON STREET				d. STREET ADDRESS 12,502 FELDON STREET				
3. NAME OF DECEASED (Type or print) First Middle Last ALZIRE (nm) DEMERS				4. DATE OF DEATH Month Day Year DECEMBER 1 19 59				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 10, 1887		9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STAPLER (retired) PAPER		10b. KIND OF BUSINESS OR INDUSTRY BOX MANUFACTURING		11. BIRTHPLACE (State or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME FABIEN LEGER				14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 062-20-9085		17. INFORMANT F. Address Spring, Md.		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH (FUND DEAD IN BED)</p> </div> </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Frank J. Brochart</i> EXAMINER'S NAME (Type) FRANK J. BROCHART				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 12/5/59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY PARISH CEMETERY		22d. LOCATION (City, town, or county) (State) OGDENSBURG, NEW YORK		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Pumphrey, Inc.</i> WARNER E. PUMPHREY, INC.				24a. REC'D BY REGISTRAR DEC 2 '59		24b. REGISTRAR'S SIGNATURE <i>Orin S. Kline</i>		

THIS MEDICAL EXAMINER'S CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGE 4 SHOULD BE FILED WITH THE REGISTRAR PRIOR TO BURIAL, CREMATION, OR REMOVAL.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13855

13893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>75 Hammond Dr.</u>				d. STREET ADDRESS <u>75 Hammond Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jimmie</u> Middle <u>Lee</u> Last <u>Derrey</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-11-59</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Jimmie C. Derrey</u>				14. MOTHER'S MAIDEN NAME <u>Rosella Lee McCauley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Rosella Derrey -</u>		Address <u>Stuen 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO <u>Upper Respiratory Infection</u> (c) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brochert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROCHERT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-5-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 7 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROY W. BARBER</u>				ADDRESS <u>Laytonsville, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

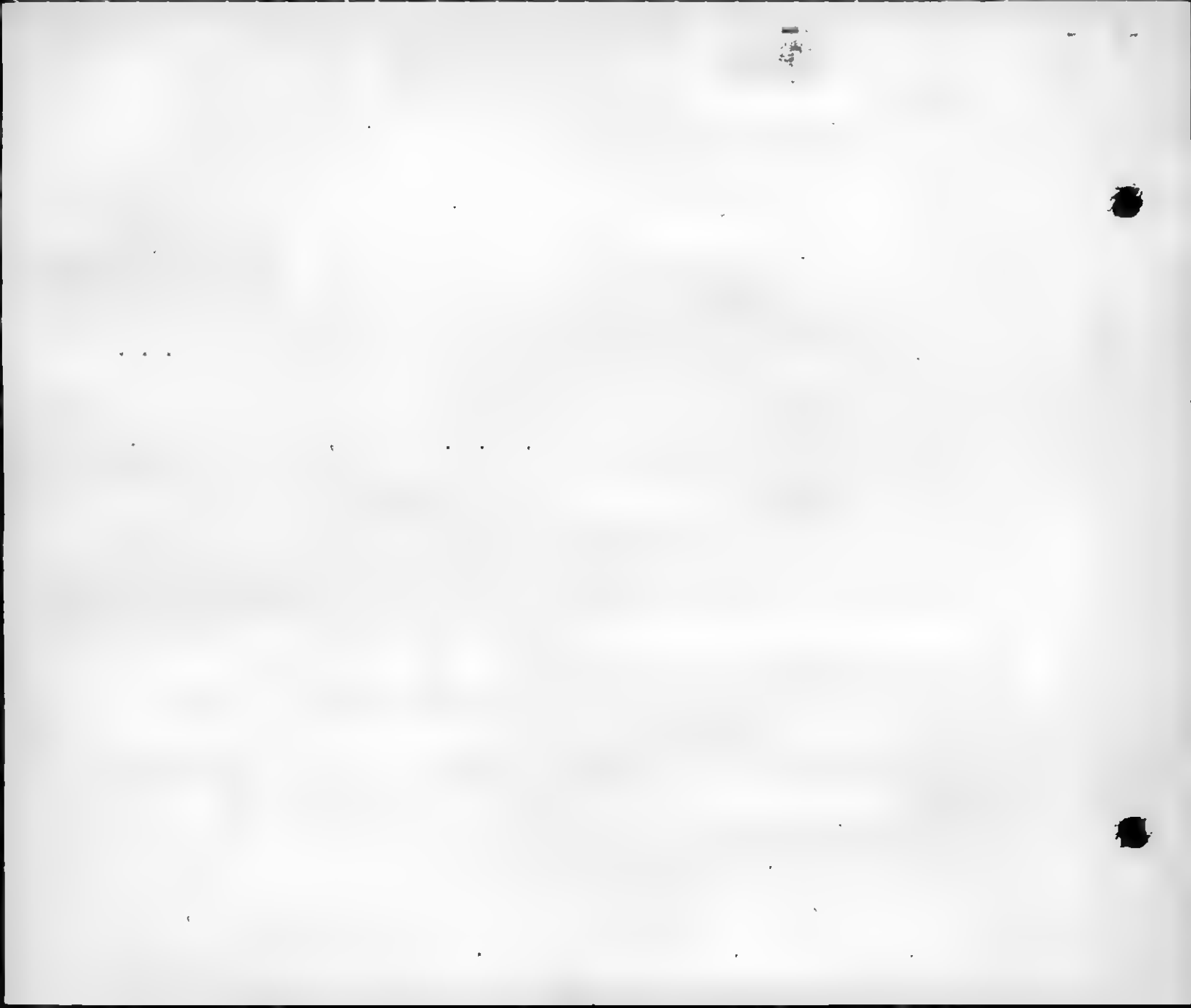
13894

CERTIFICATE OF DEATH

Reg. Dist. No.

13856

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>5 Days 8 1/2 hrs</u>		d. STREET ADDRESS <u>17809 Boston Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ma E</u> Middle <u>T.</u> Last <u>Edwards</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-87</u>
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Leonard Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Myra Travis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT Address <u>Mrs. Wm. T. Lackland, 7809 Boston Ave. Silver Spring, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>401.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic fever</u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>30 Dec</u> , 1959, that I last saw the deceased alive on <u>30 Dec 59</u> , 19 <u> </u> , and that death occurred on <u>11:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Aud</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>9006 Glenville Rd 12/30/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/2/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>			



13893

CERTIFICATE OF DEATH

Reg. Dist. No. 13837

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>6 yrs</u>		d. STREET ADDRESS <u>2102 Dexter Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2102 Dexter Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Eslin</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 26 1869</u> 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years lost birthday) <u>90</u> yrs. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Michael J McMahon</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr Henry C Eslin</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive Heart Failure</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> DUE TO (b) <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Accident</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> p. m. <u>19</u> Month, Day, Year	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>Dec 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>59</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Lawrence Avery</u> M.D.		ADDRESS (Street, city or town, state) <u>10110 Georgia Ave Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u>		DATE SIGNED <u>12/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Dec 30, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>JOHN'S CHURCH</u>	22d. LOCATION (City, town, or county) (State) <u>Forest Glen MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Tallantree</u> ADDRESS <u>3603 14th ST NW Wash. DC</u>		24a. REC'D BY REGISTRAR <u>DEC 30 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



CERTIFICATE OF DEATH

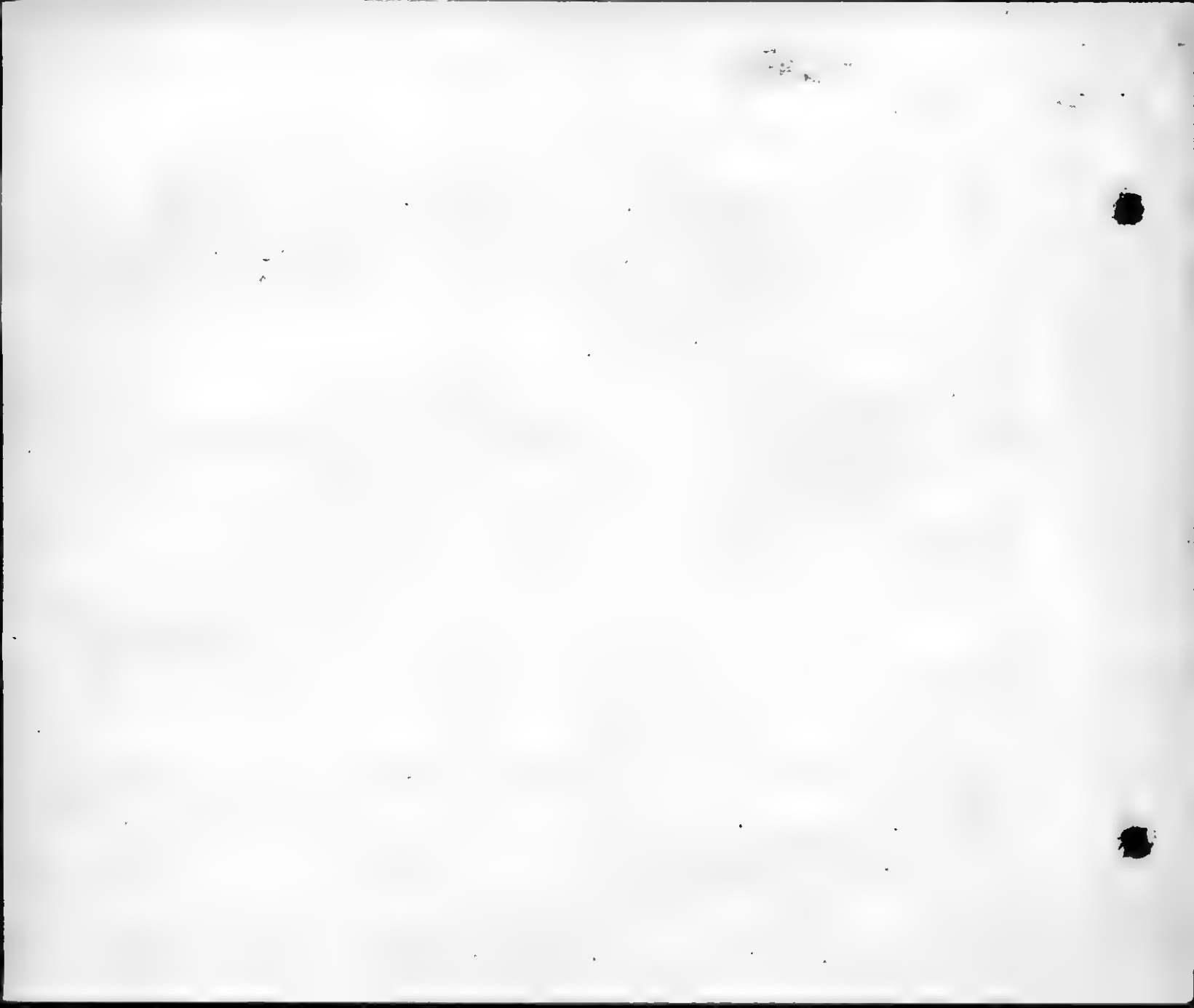
Reg. Dist. No. 215

13896

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 181 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 5510 Hoover Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dean		First Dean		Middle (n)		Last FARNSWORTH	
4. DATE OF DEATH December		Month December		Day 27		Year 1959	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-22-02	
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elmer Farnsworth				14. MOTHER'S MAIDEN NAME Angeline Small			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		INFORMANT (Wife) Ruth B. Farnsworth Same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 147X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA HYPOTHARYNX DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 June, 1959, to 27 December, 1959, that I last saw the deceased alive on 27 December, 1959, and that death occurred at 12:10 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 12-28-59							
ACTUAL SIGNATURE George W. Taylor Jr.				M.D. U.S. Naval Hospital, Bethesda, Md. 12-28-59			
PHYSICIAN'S NAME (Type) G.W. TAYLOR CDR MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12-28-59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers 1400 Chapin Street N.W. Washington				24a. REC'D BY REGISTRAR DATE DEC 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be received by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

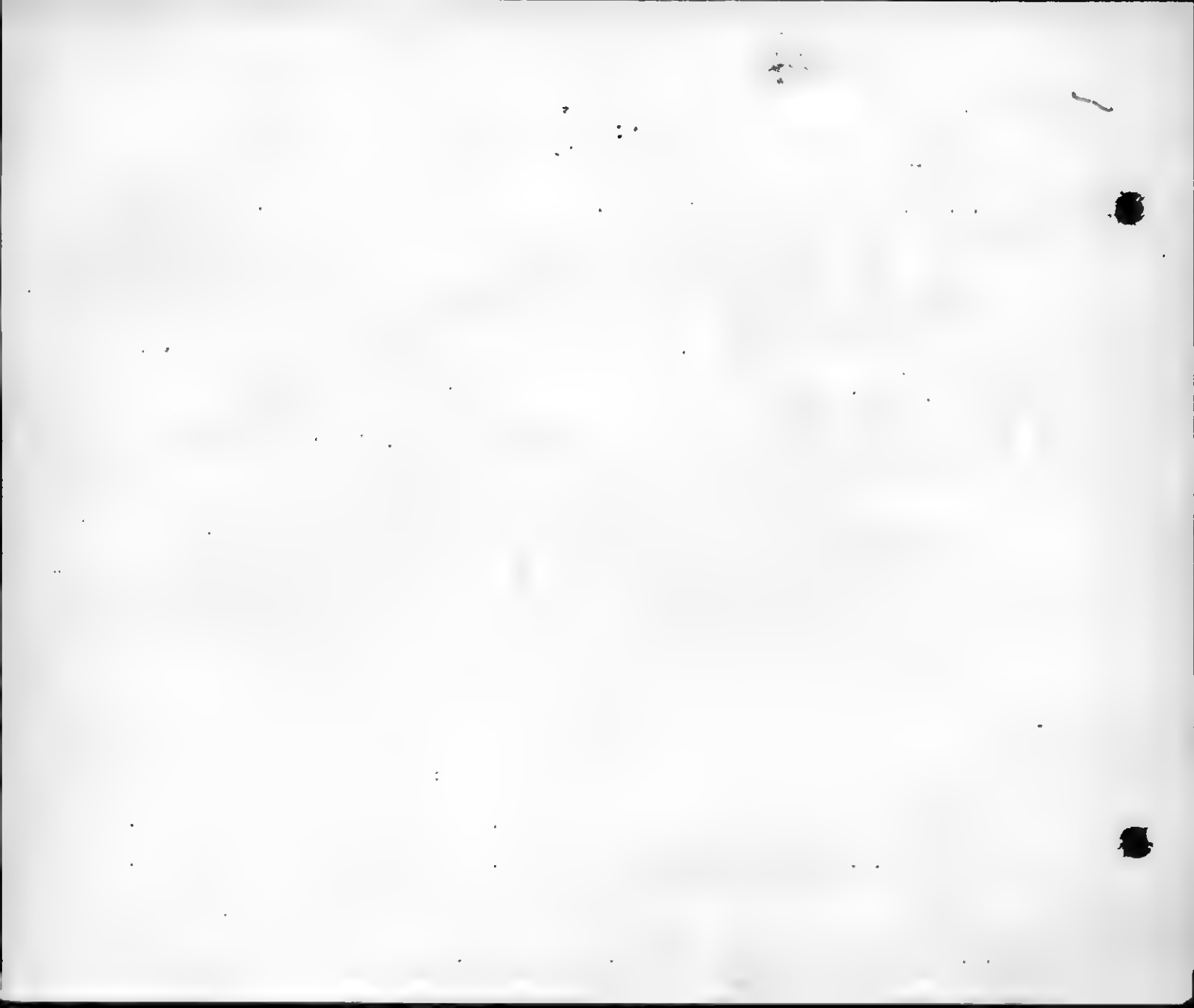
1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**
 Item 4 Film 2254 1-13-60 et
13897 **CERTIFICATE OF DEATH**

13839

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington			
c. LENGTH OF STAY IN 1b 2 days				d. STREET ADDRESS 626 South Stafford St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Leigh Last FASER				4. DATE OF DEATH Month December Day 23 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-21-59	
9. AGE (In years lost birthday) 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Karl E. Faser				14. MOTHER'S MAIDEN NAME Mary Elizabeth SHANAHAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT (Father) Karl E. Faser Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and collapse DUE TO Conditions, if any, which gave rise to immediate cause (b) Septicemia in the newborn DUE TO Probably caused by maternal bacteremia lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 day 2 days						INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 December, 1959 to 23 December, 1959 , that I last saw the deceased alive on 23 December, 1959 , and that death occurred at 3:00 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 12-23-59							
ACTUAL SIGNATURE G.B. Avery				M.D. U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) G.B. Avery LT MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumhrey ADDRESS 7557 Wisconsin, Ave. Bethesda Md.				24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kemp	

2051332XJ4



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13840

13898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>3 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8606 Barron st</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8606 Barron st</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Federman</u> Last <u></u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1959</u>		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>11-26-1896</u> 9. AGE (In years last birthday) <u>68</u> ym.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Stationery Supplies N.Y.C.</u> 11. BIRTHPLACE (State or foreign country) <u>N.Y.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Federman</u> 14. MOTHER'S MAIDEN NAME <u>Rachael Federman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>072-10-0076</u> 17. INFORMANT <u>Pauline Federman (wife)</u> Address <u>Itm 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-6-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/8-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt Hope</u>			
22d. LOCATION (City, town, or county) (State) <u>Hastings on the Neck Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash. D.C.</u> ADDRESS _____					
24a. REC'D BY REGISTRAR <u>DEC 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

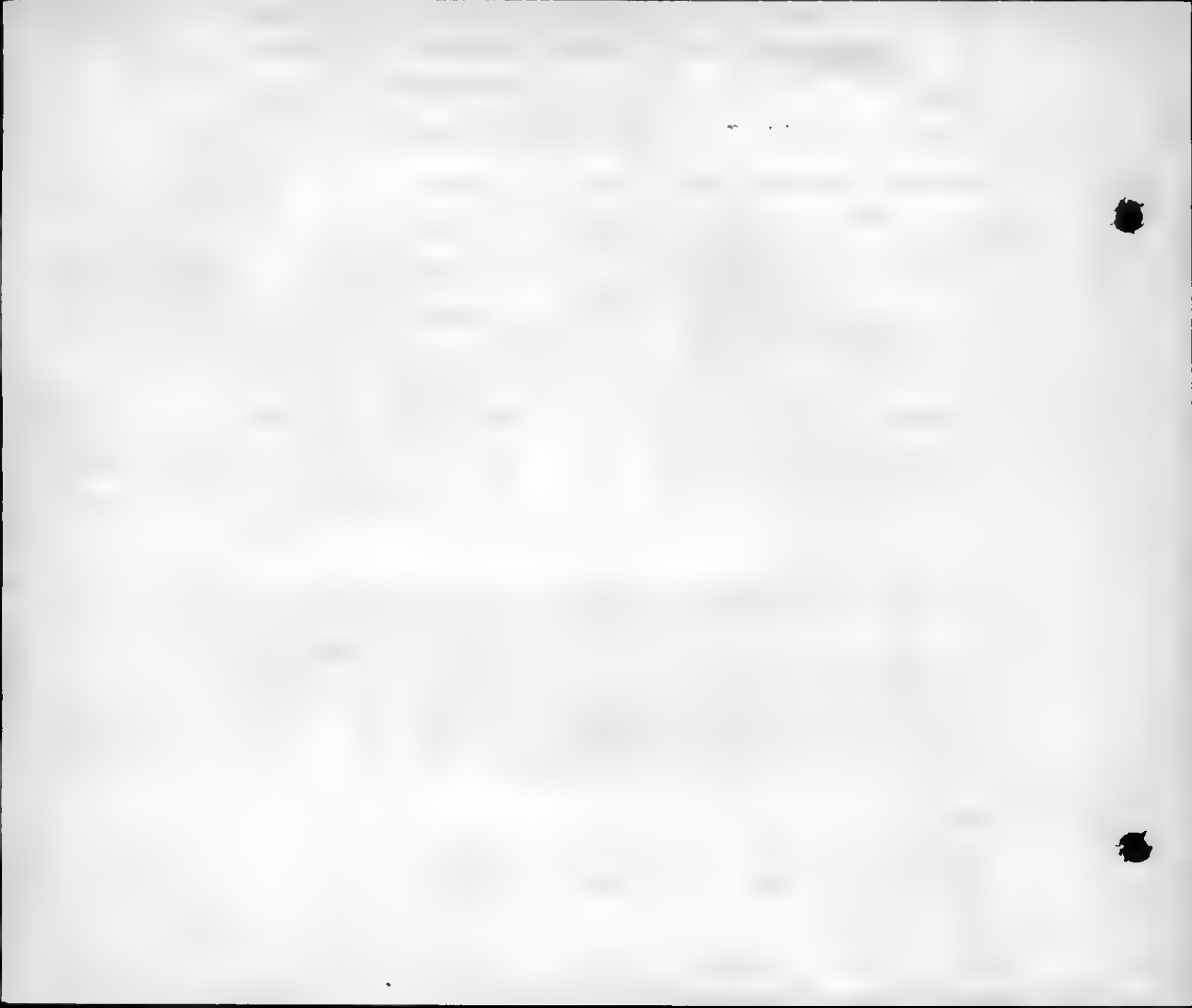
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13832 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>710 Boundary Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Emily</u> Last <u>Field</u>				4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1959</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-8-58</u>		9. AGE (in years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hours <u>19</u> Min. <u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Lawrence I. Field</u>						14. MOTHER'S MAIDEN NAME <u>Ruth Bisen</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mother</u> Address <u>710-BOUNDARY AVE</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>410X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Upper Respiratory Infection</u> DUE TO <u>2 days</u> (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>—</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Frank J. Broschelt</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>12-24-59</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschelt</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>12/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NATL. MEM. PARK</u>				22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geedberg Funeral Home</u>						ADDRESS <u>4217-9th Ave</u>		24a. REC'D BY REGISTRAR <u>DEC 28 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13842

Reg. Dist. No.

13899

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. LENGTH OF STAY IN lb <u>15 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3614 Sheppard St.</u>				d. STREET ADDRESS <u>3614 Sheppard St.</u>			
3. NAME OF Also known as First Frederick Middle Wm. Spletstoser (Type or print) <u>Frederick William Fischer</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>31</u> Year <u>1955</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-28-1895</u>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>64 yrs.</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Representative</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Mich.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Frederick Wm. Spletstoser</u>				14. MOTHER'S MAIDEN NAME <u>Eliz Fischer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW #1</u>		17. INFORMANT <u>Allice Fischer (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Consultant</u> (c) <u>middle</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Blaschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Blaschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. & BURIAL</u>		<u>1/5/60</u>		<u>Jackson, Michigan</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PIMPERFY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.



13900

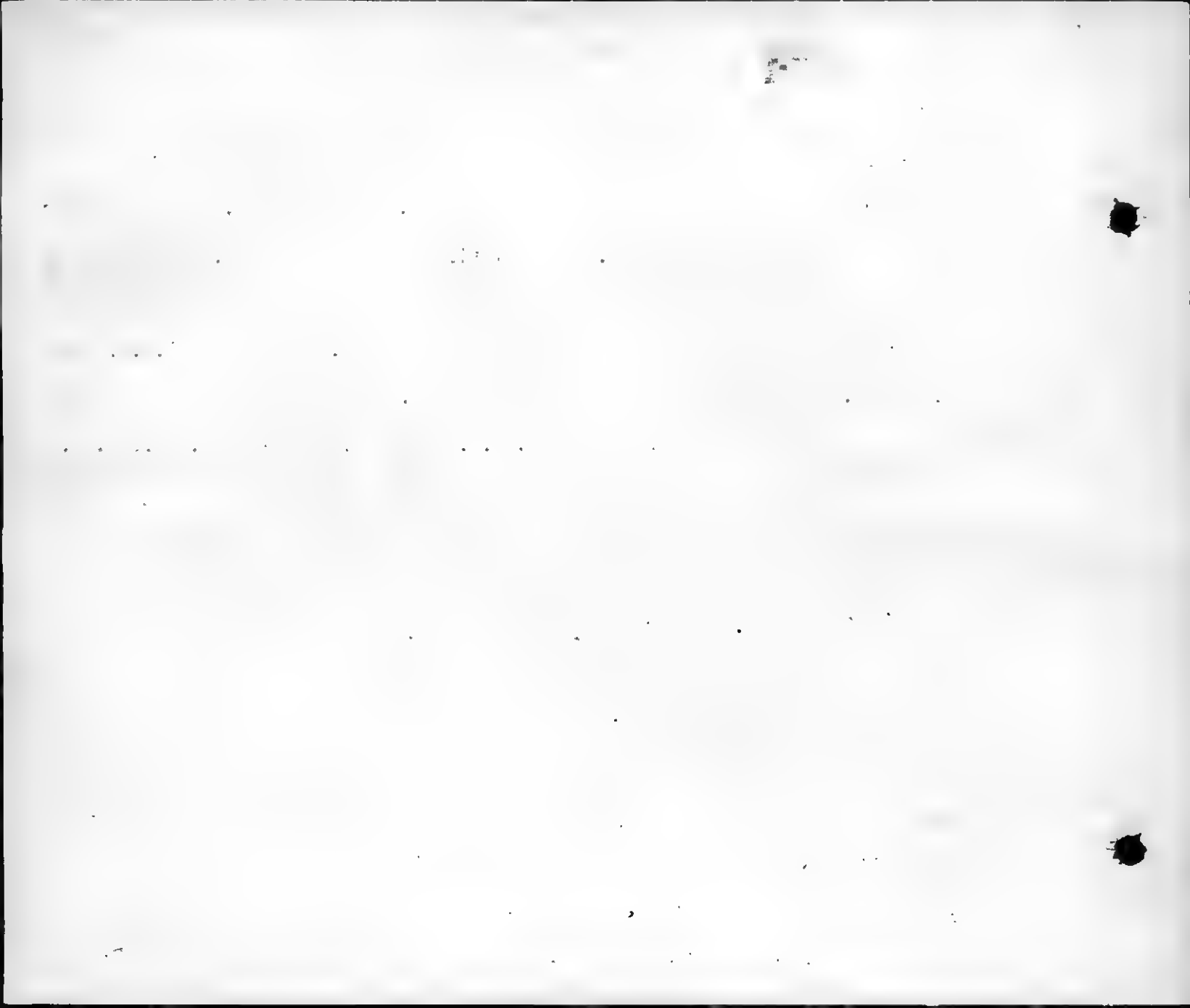
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
		f. STREET ADDRESS 300 N. Frederick Ave.	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lenganore Middle A. Last Fitzsimmons		4. DATE OF DEATH Month Dec. Day 8 Year 19 59	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/76
9 AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Lenganore, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William F. Boland		14. MOTHER'S MAIDEN NAME Emma G. Poole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Yes	
INFORMANT Mrs. H. H. Ramsdell, 3690 - 38th. St., N. W.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular renal disease		INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-29 , 19 59 , to 12-8 , 19 59 , that I last saw the deceased alive on 12-8-59 , 19 , and that death occurred at 7:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Morris Perry		ADDRESS (Street, city or town, state) 11602 Georgia Ave Silver Spring Ind.	
PHYSICIAN'S NAME (Type) Morris Perry		DATE SIGNED 12-8-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/59	
22c. NAME OF CEMETERY OR CREMATORY St. Rose Cemetery		22d. LOCATION (City, town, or county) (State) Gaithersburg, R.F.D. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. C. Burton ADDRESS Gaithersburg, Md.		24a. REC'D BY REGISTRAR DEC 10 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

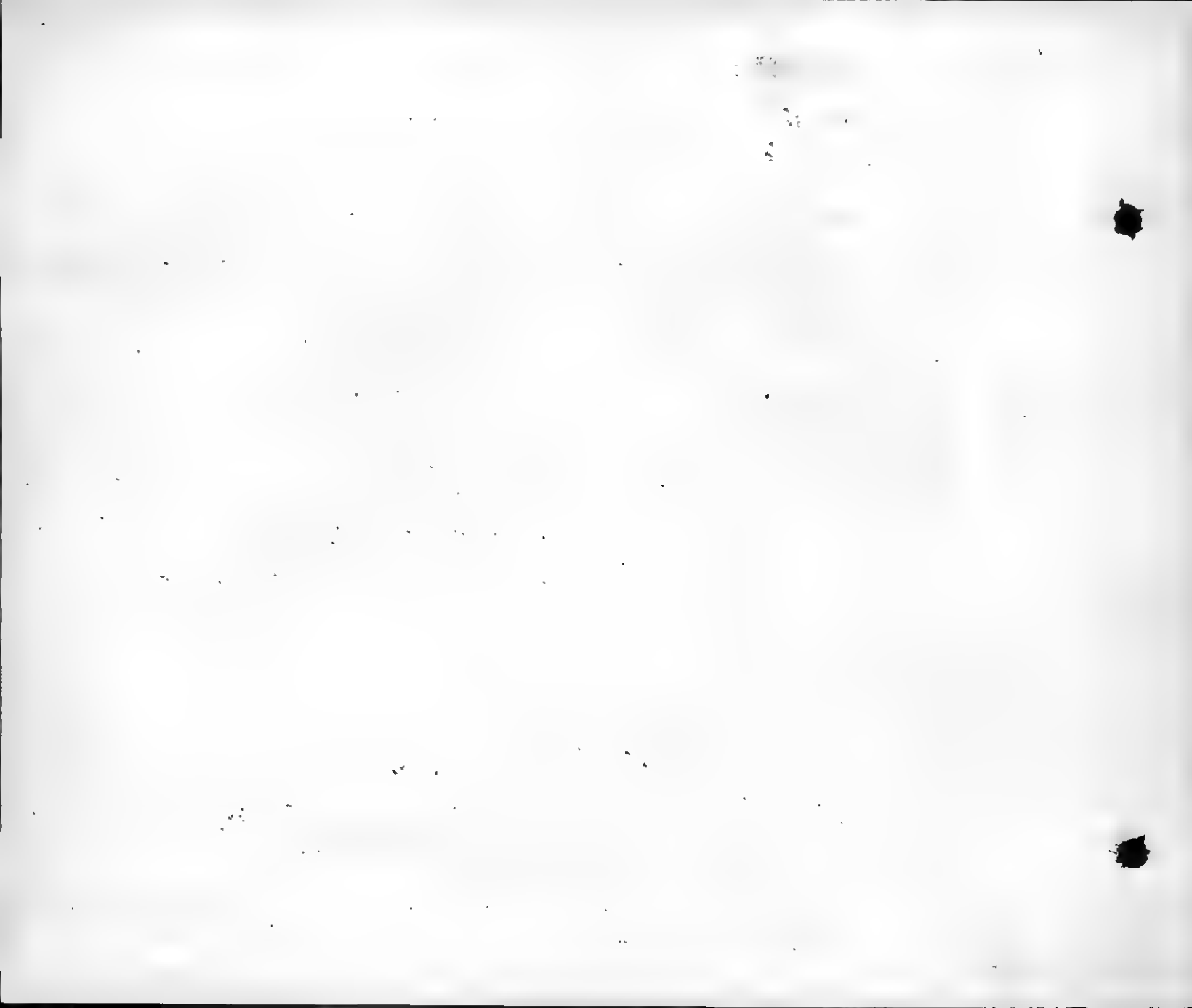
13844

13901

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 19 days		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles O. Fowler		4. DATE OF DEATH Month Day Year Dec. 3 1959		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. BIRTHPLACE (State or foreign country) VILLA GROVE, ILL		9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. KIND OF BUSINESS OR INDUSTRY Lawyer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James M. Fowler		14. MOTHER'S MAIDEN NAME Laura Overman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. (Wife) Same as Above		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Cerebral Vascular Occlusion Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Hypertension - Arteriosclerosis Generalized (b) 7 Years (c) 48-72 hrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from June 1955 to 12-3 , 1959, that I last saw the deceased alive on Dec. 3 , 1959, and that death occurred at 8:38 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 4201 FESSENDEN ST NW Washington D.C. 12-3-59	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 12/7/59		22c. NAME OF CEMETERY OR CREMATORY Greenwood		22d. LOCATION (City, town, or county) (State) Michigan City, Ind		23. FUNERAL DIRECTOR'S SIGNATURE James B. Bell	
24a. REC'D BY REGISTRAR DEC 7 '59		24b. REGISTRAR'S SIGNATURE Arthur D. H. H.		24c. REGISTRAR'S NAME Arthur D. H. H.		24d. REGISTRAR'S ADDRESS Wisc. Ave. N.W.		24e. REGISTRAR'S PHONE Wisc. Ave. N.W.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13902

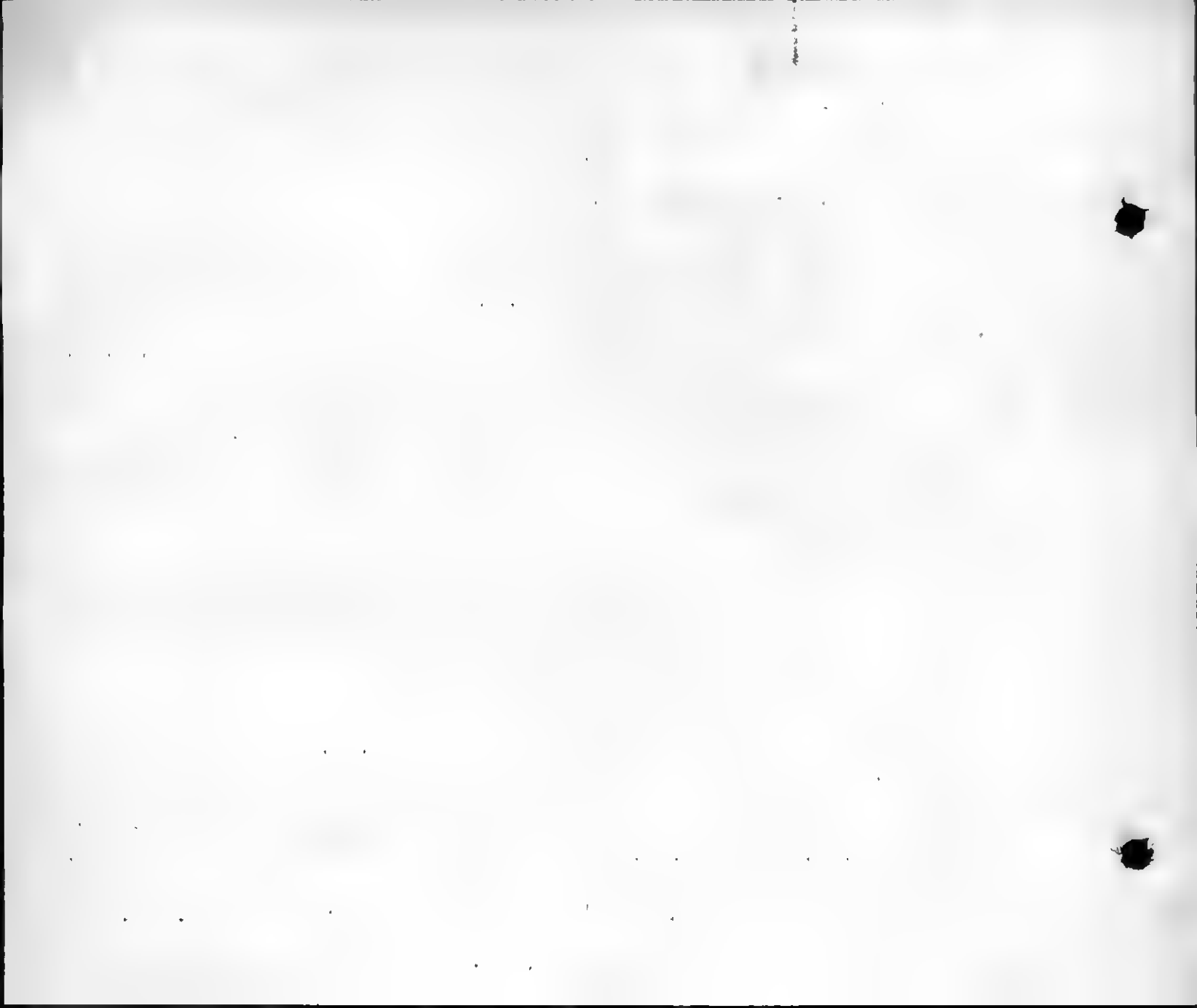
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 1/2 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Medical Center, Sandy Spring, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Wyckoff Last Fraley		4. DATE OF DEATH Month 12 Day 29 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1.11.96
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Kinney		14. MOTHER'S MAIDEN NAME Violet Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Hospital Records, Olney, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1/2 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/1 , 19 59 , to 12.29.59 , that I last saw the deceased alive on 12.29.59 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Center, Sandy Spring, Md. DATE SIGNED C. H. Ligon			
ACTUAL SIGNATURE C. H. Ligon		PHYSICIAN'S NAME (Type) C. H. Ligon, M. D., Medical Center, Sandy Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-1-60	22c. NAME OF CEMETERY OR CREMATORY St. Luke's Lutheran	22d. LOCATION (City, town, or county) (State) Redland, Mont. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR JAN 4 '60	24b. REGISTRAR'S SIGNATURE C. H. Ligon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

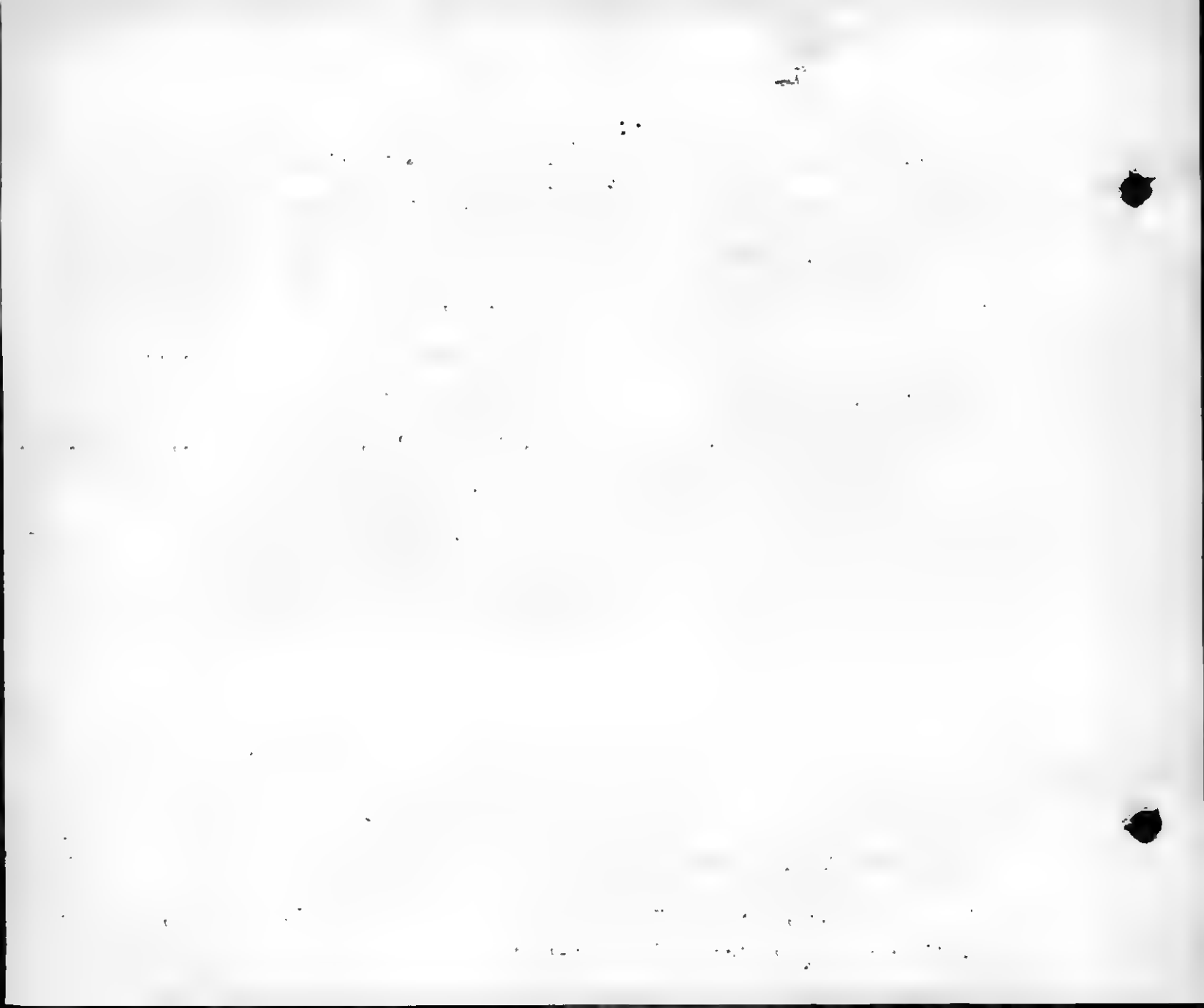
13903

CERTIFICATE OF DEATH

Reg. Dist. No.

13849

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 1 day 17 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PAUL A. FRANCESCO		4. DATE OF DEATH Month Day Year DECEMBER 24 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 22, 1959
9. AGE (In years last birthday) 0 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 0 1 17 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DOMINICK L. FRANCESCO		14. MOTHER'S MAIDEN NAME HELEN PATRICIA SCHUTZLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MRS. EVELYN TAUBER, 123 TALBOTT ST., ROCKVILLE, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple congenital anomalies of central nervous system defects DUE TO (b) 2 days - DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 22, 1959 to Dec 24, 1959 that I last saw the deceased alive on Dec 24, 1959 and that death occurred at 4 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12020 Georgia Silver Spring, Md. DATE SIGNED 12/25/59			
ACTUAL SIGNATURE Patrick C. Jameson M.D.		PHYSICIAN'S NAME (Type) PATRICK C. JAMESON	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 26, 1959	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc., Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			



CERTIFICATE OF DEATH

13846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>20 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Buckle Creek Foundation</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Rose</i> Middle <i>Friedman</i> Last		4. DATE OF DEATH Month <i>Dec</i> Day <i>5</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 14 1884</i>
9. AGE (In years last birthday) yrs <i>75</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House duties</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Hyman Friedman</i>		14. MOTHER'S MAIDEN NAME <i>Hanna Greenfield</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Albert Rothner</i>		Address <i>NE 113 447 Madison Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>350X</i> DUE TO <i>Bronchopneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Parkinsonism</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>YKS</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/12</i> , 19 <i>59</i> , to <i>12/5</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/4</i> , 19 <i>59</i> , and that death occurred at <i>7:01 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. H. Ligon</i>		ADDRESS (Street, city or town, state) <i>Sandy Spring, Md</i>	
PHYSICIAN'S NAME (Type) <i>C. H. Ligon</i>		DATE SIGNED <i>12/5/59</i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/6-1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park Falls Church Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i>		ADDRESS <i>Wash. DC</i>	
24a. REC'D BY REGISTRAR <i>DEC 8 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13847

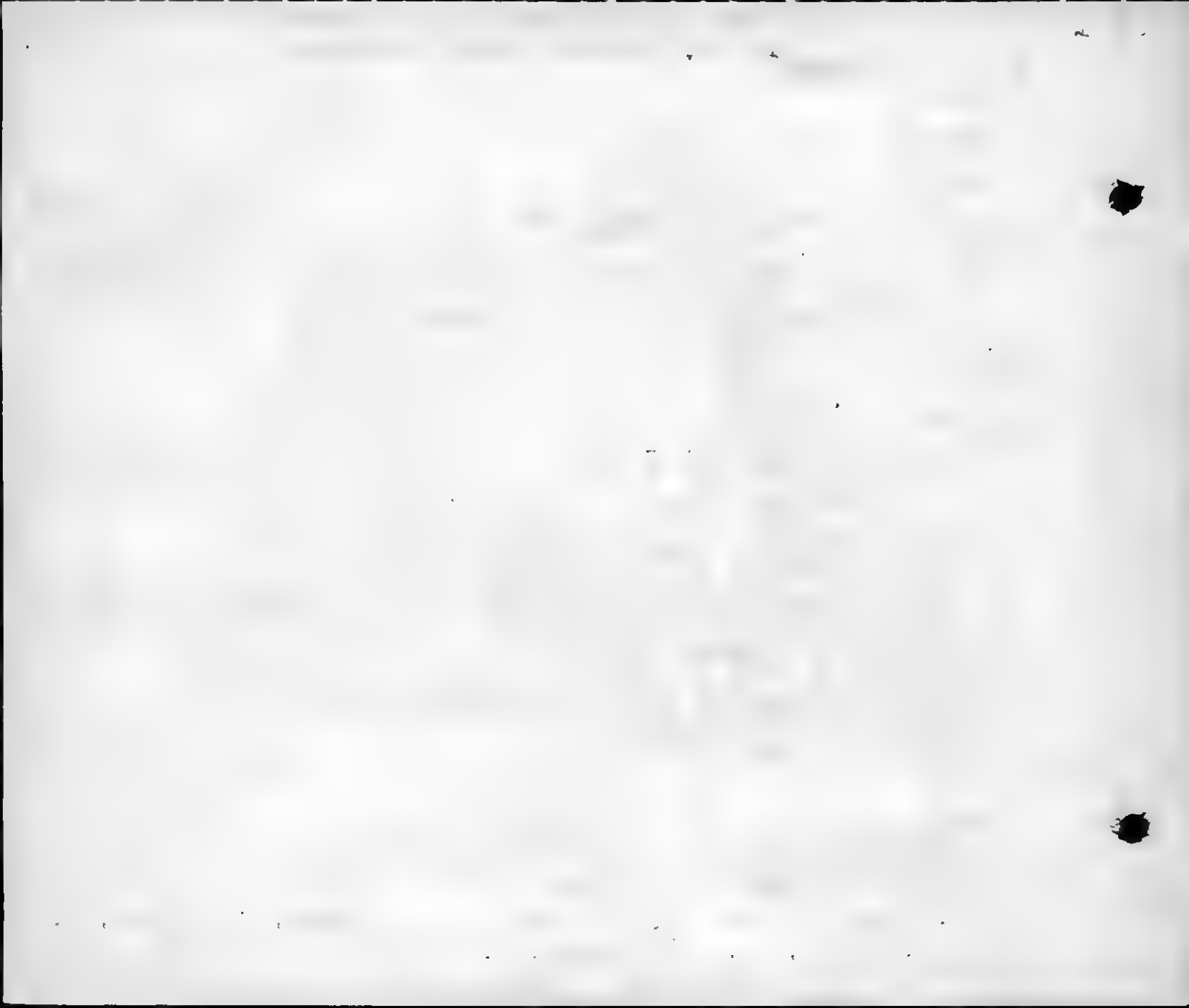
Reg. Dist. No.

13905

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>10 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2238 Washington Ave - Apt 102</u>				d. STREET ADDRESS <u>2238 Washington Ave - Apt 102</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Franklin Harrison Funk</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1917</u>		9. AGE (In years last birthday) <u>42 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.O. Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles A. Funk</u>				14. MOTHER'S MAIDEN NAME <u>Alise Tammey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>171-09-2223</u>		17. INFORMANT <u>Elaine Funk (wife)</u>		Address <u>Stems</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>12/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLSIDE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FULLERTON, LEHIGH COUNTY, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13906

CERTIFICATE OF DEATH

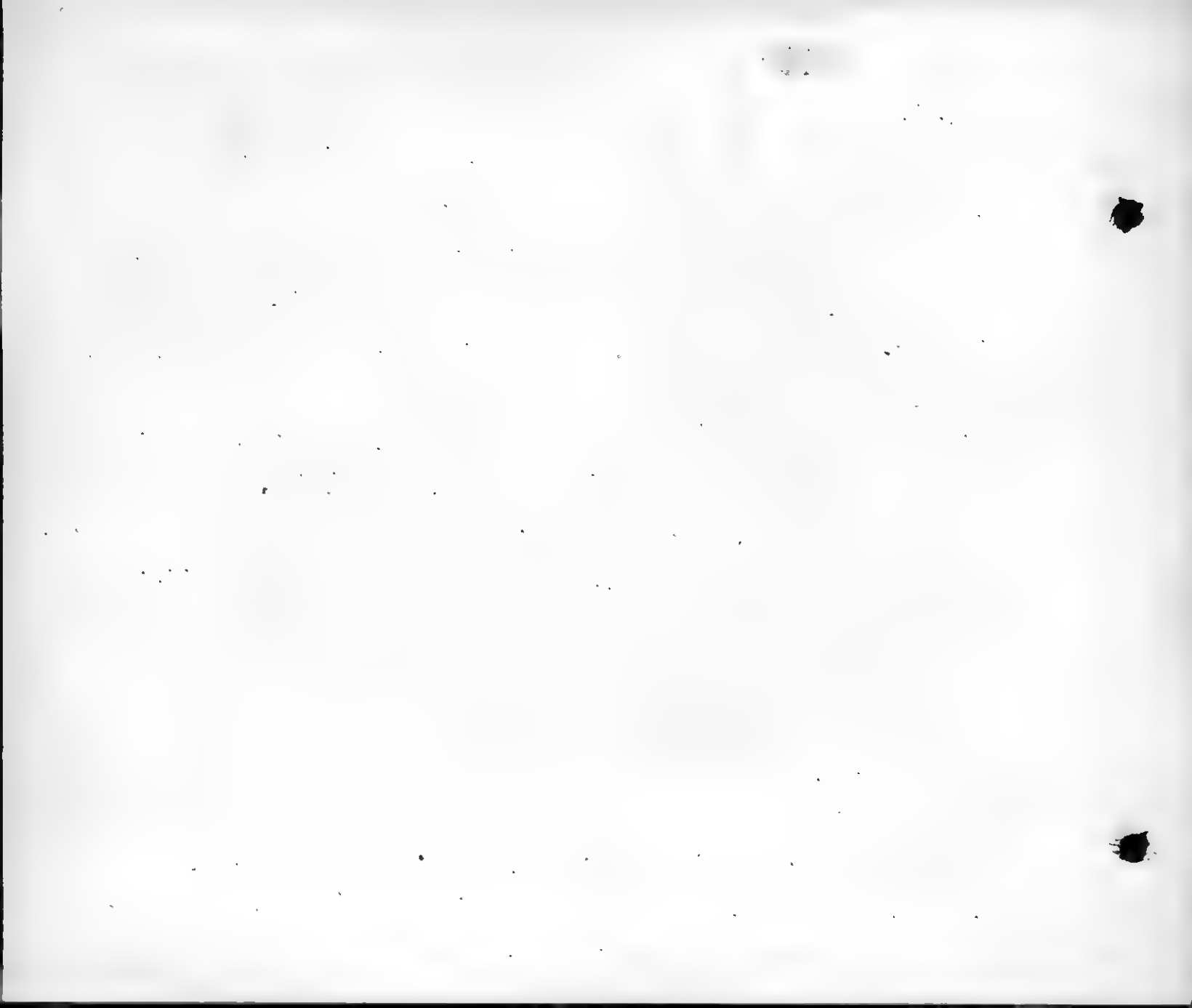
Reg. Dist. No.

13848

1. PLACE OF DEATH a. COUNTY <u>Adams</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>47X3</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. 16 D. C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>5016 45th N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ching</u> Middle <u>Clay</u> Last <u>FUTR</u>				4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 15 1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR: Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Nicely</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>57909-6061</u>		INFORMANT <u>5016 45th N.W. Markle</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Congestive Heart Failure</u> 48 hours (c) <u>Hypertension Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-26, 1959</u> , to <u>12-26, 1959</u> , that I last saw the deceased alive on <u>12-26, 1959</u> , and that death occurred at <u>8:37 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>P. P. Andrews</u> M.D. <u>4201 Fessenden St N.W. 12-26-1959</u>				PHYSICIAN'S NAME (Type) <u>P. P. ANDREWS, M.D. Washington D.C.</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUNERAL HOME</u>				ADDRESS <u>4812 Ga Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13907

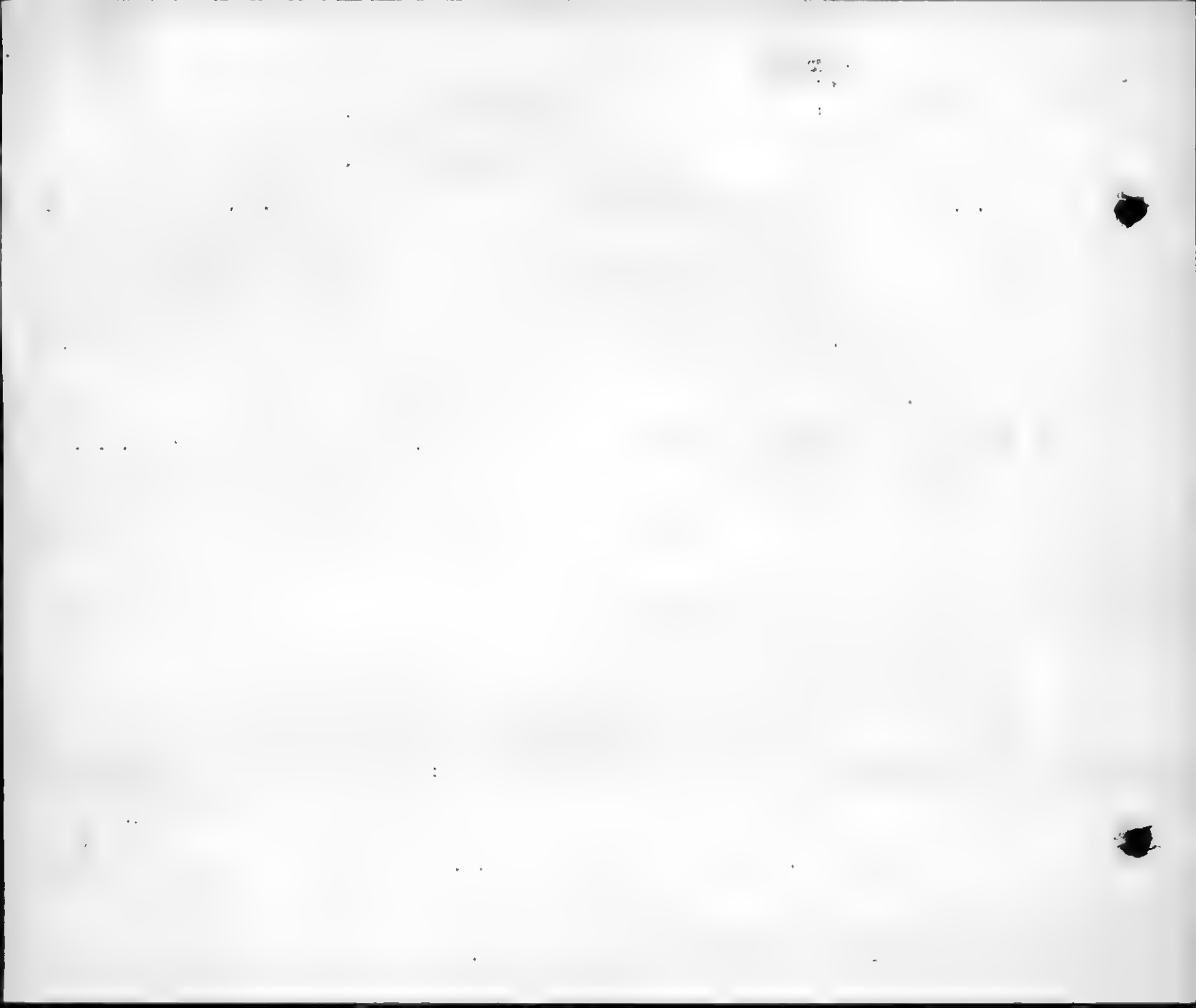
CERTIFICATE OF DEATH

Reg. Dist. No.

13850

1 PLACE OF DEATH a. COUNTY Montgomery County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bethesda, Md.		c. LENGTH OF STAY IN lb 88 days		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		d. STREET ADDRESS 5215 Massachusetts Ave. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Leslie Tracy GAGER		4. DATE OF DEATH Month Day Year December 25 1959		5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 27 1890		9. AGE (In years lost birthday) yrs. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY Medical		11 BIRTHPLACE (State or foreign country) Connecticut		12 CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME John A. Gager		14. MOTHER'S MAIDEN NAME Luella Tracy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
16 SOCIAL SECURITY NO. Unknown		INFORMANT Josephine C. Gager		Address 5215 Mass Ave, W.D.C.		18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia (organism unknown)</u> 704.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia Follicular</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 months		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>September 28, 1959</u> , to <u>December 25, 1959</u> , that I last saw the deceased alive on <u>December 25, 1959</u> , and that death occurred at <u>2:53 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James M. Young</u> M.D. <u>U.S. Naval Hospital, Bethesda Md.</u> <u>12-26-59</u> PHYSICIAN'S NAME (Type) <u>James M. YOUNG LT MC USN</u> <u>U.S. Naval Hospital, Bethesda, Maryland</u>	
22a. BURIAL, CREMAT., OR REBURY (Specify) Burial		22b. DATE THEREOF <u>12-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia		23. FUNERAL DIRECTOR'S SIGNATURE <u>De Vol Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

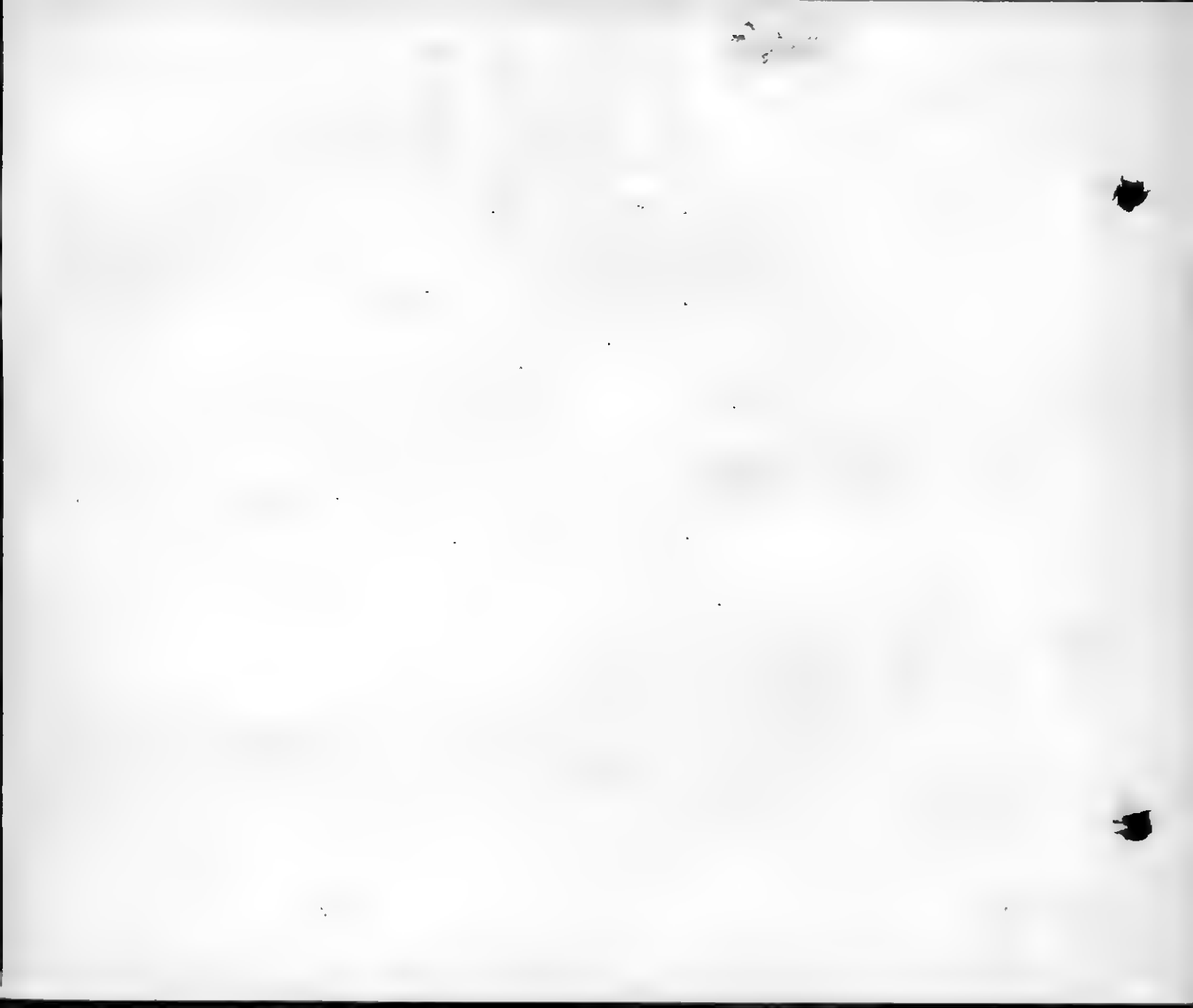
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13833

CERTIFICATE OF DEATH

Reg. Dist. No. 13851

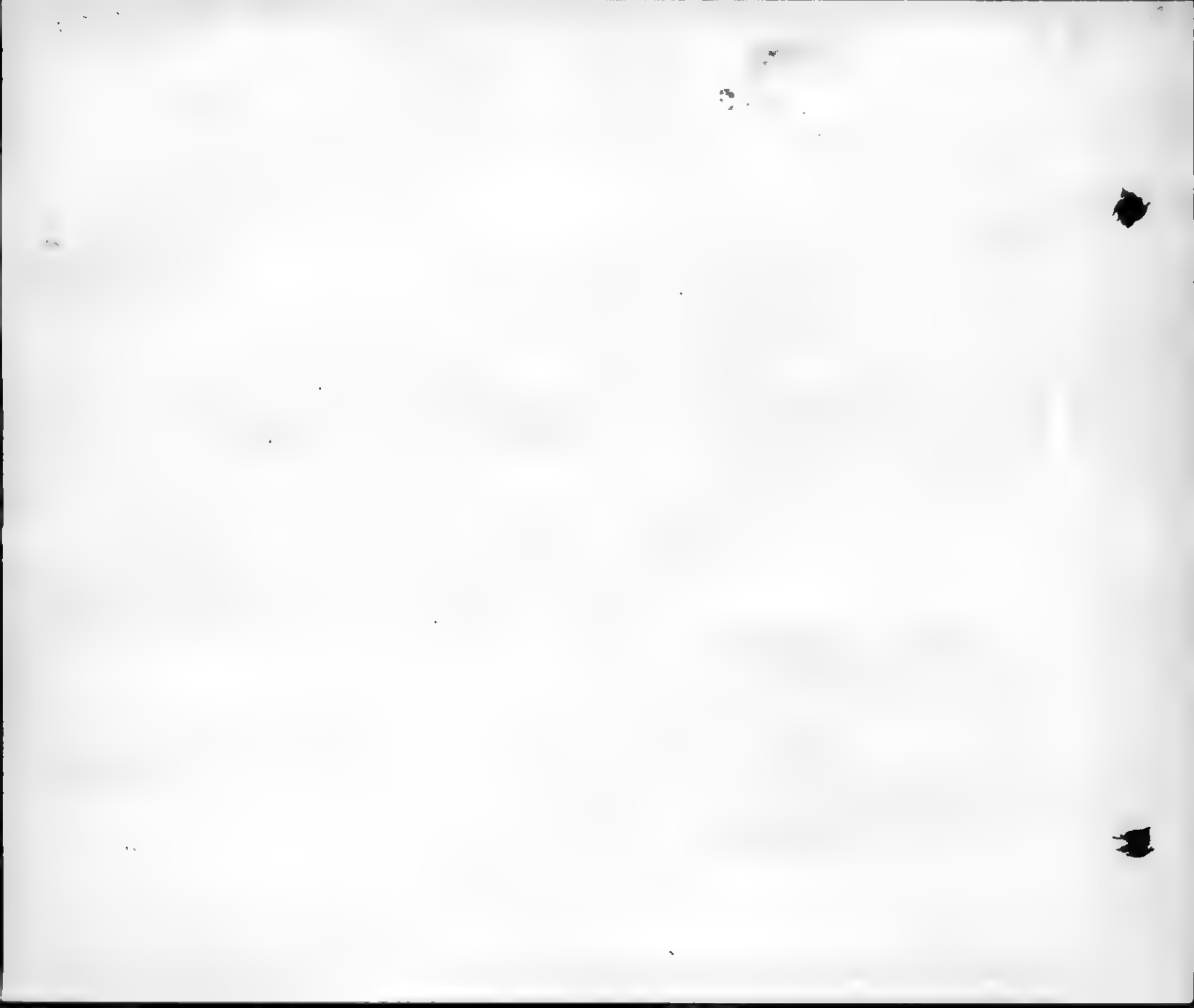
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>				e. STREET ADDRESS <u>12905 Bluff Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>(NMN)</u> Last <u>Garfinhel</u>				4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-86</u>		9. AGE (In years last birthday) <u>73</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY (1) <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Kontorsky</u>				14. MOTHER'S MAIDEN NAME <u>Libby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>Son</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction due to coronary occlusion (left anterior descending branch)</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-14, 1959</u> to <u>12-16, 1959</u> that I last saw the deceased alive on <u>12-16, 1959</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Heiger</u>				ADDRESS (Street, city or town, state) <u>M.D. 931 Pershing Drive, Silver Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u> </u>				DATE SIGNED <u>12-16-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BROOKLYN. N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Soldberg Funeral Home 4217 94th Ave</u>				24a. REC'D BY REGISTRAR <u>DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



13952

VS A15 (4)
15M 9/5B

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if deceased before admission) a. STATE <u>N. C.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Chapel Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>		d. STREET ADDRESS <u>1337 Rockhill Rd.</u> #1 <u>Brandon Road</u>	
3. NAME OF DECEASED (Type or print) <u>Barbara</u> First <u>Wighton</u> Middle <u>Garkitt</u> Last		4. DATE OF DEATH Month <u>12</u> - Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7 - 1884</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Donald Mc Guire</u>	
14. MOTHER'S MAIDEN NAME <u>Jane Doctor</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Daughter:</u> <u>Mrs. Arthur Roe</u> Address <u>5357 Rockhill Rd. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Renal Shut down</u> DUE TO (c) <u>Constrictive Heart Failure due to Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Due to Malabsorption Syndrome Secondary to Gastroenteritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>2 wks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 3</u> , 19 <u>59</u> to <u>December 9</u> , 19 <u>59</u> that I last saw the deceased alive on <u>December 9</u> , 19 <u>59</u> , and that death occurred at <u>340</u> P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>5800 Beech Ave, Bethesda, Md.</u> DATE SIGNED	
ACTUAL SIGNATURE <u>Edward Lewis Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 14, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wynmore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wynmore, Nebraska</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St NW DC.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Clifford S. Evans</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13853

13908

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mm</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>18 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7104 Delaware St</u>				d. STREET ADDRESS <u>7104 Delaware St</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph A.</u> Middle <u>Gargiulo Jr.</u> Last <u></u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH <u>10-9-1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trust Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nat. Saving & Trust Co</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>				13. FATHER'S NAME <u>Joseph A. Gargiulo</u>			
14. MOTHER'S MAIDEN NAME <u>Margaretta Myer</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>577-03-4517</u>				17. INFORMANT <u>Class Hensley</u> Address <u>8516 Beach Tree Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> DUE TO (b) <u>Gun shot wound -</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (c) <u>Head partially decapitated</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Repaired to have skull with C.A. of fracture with metastasis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>12-10-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kensico Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Valhalla N.Y.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gargiulo Jr.</u>					
24a. REC'D BY REGISTRAR DATE <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No.

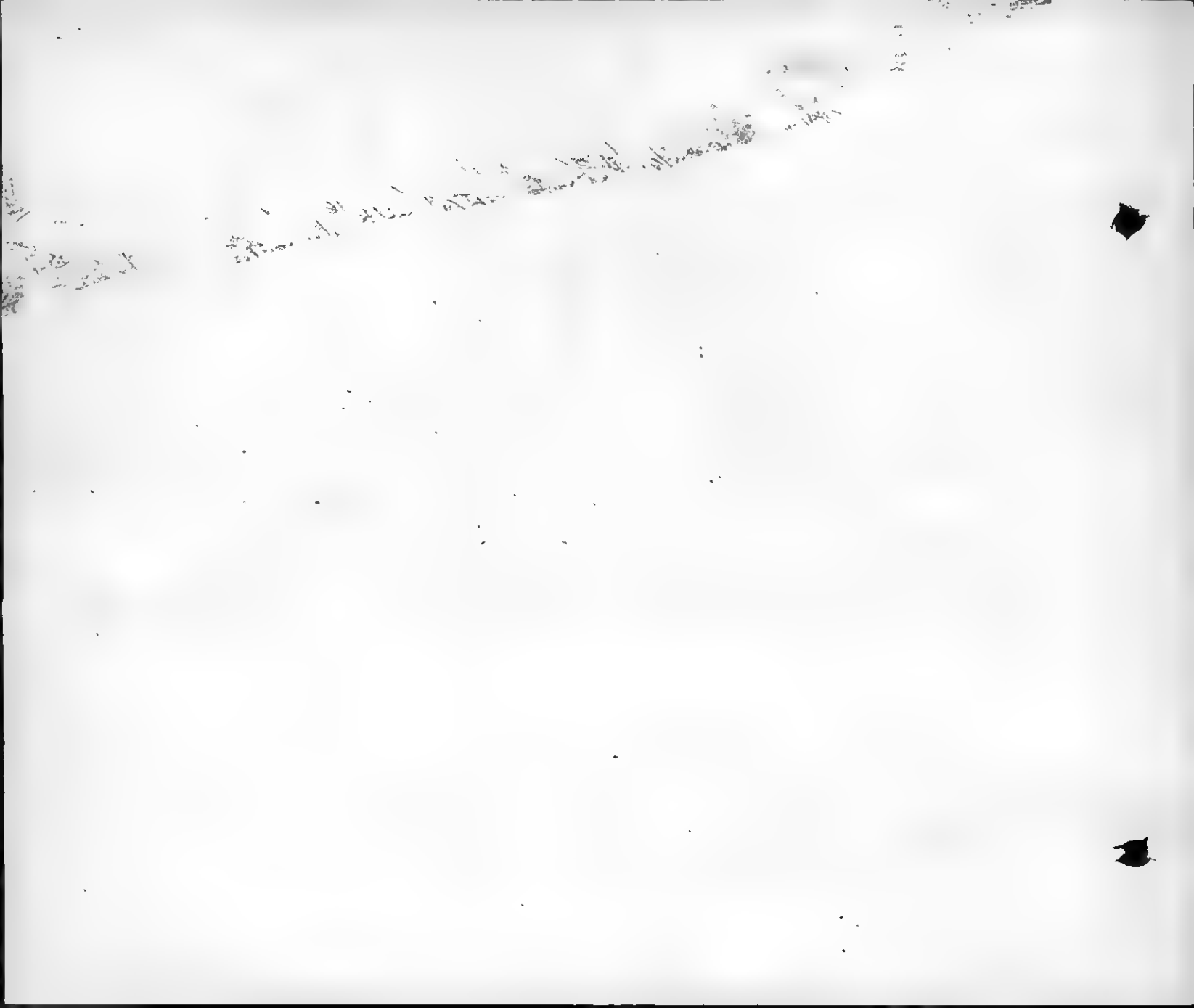
13854

13909

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>May</u> Last <u>Gooding</u>				4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/99</u>	9. AGE (In years last birthday) <u>60</u> yrs	IF UNDER 1 YEAR Months <u>60</u> Days <u>27</u> Hours <u>19</u> Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Rufus King</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>R</u>				INFORMANT <u>Edward T. Gooding, 509 Copley Lane, Silver Spring Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive pulmonary embolism</u> 463X DUE TO <u>Thrombophlebitis, left leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>8 days</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>June</u> 19 <u>57</u> , to <u>Dec 27</u> 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>943</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Sealy</u> M.D. <u>1835 Eye St. N.W.</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>12-31-59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>			
22d. LOCATION (City, town or county) (State) <u>Fredrick Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lewis - Wash. D.C.</u>			
24a. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13855

13858

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 26 Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) #2 Alsace Lane				d. STREET ADDRESS #2 Alsace Lane			
3. NAME OF DECEASED (Type or print) First Francis Middle S. Last Gospodarek				4. DATE OF DEATH Month Dec. Day 8 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 5, 1959	
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 3 Days 3		IF UNDER 24 HRS. Hours 3 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Francis S. Gospodarek				14. MOTHER'S MAIDEN NAME Mary P. Brosnan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Francis S. Gospodarek-father-same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 475X DUE TO Conditions, if any, which gave rise to immediate cause (b) Upper respiratory infection (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Found dead in bed
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/59		22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE DEC 10 '59	
				24b. REGISTRAR'S SIGNATURE Charles L. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

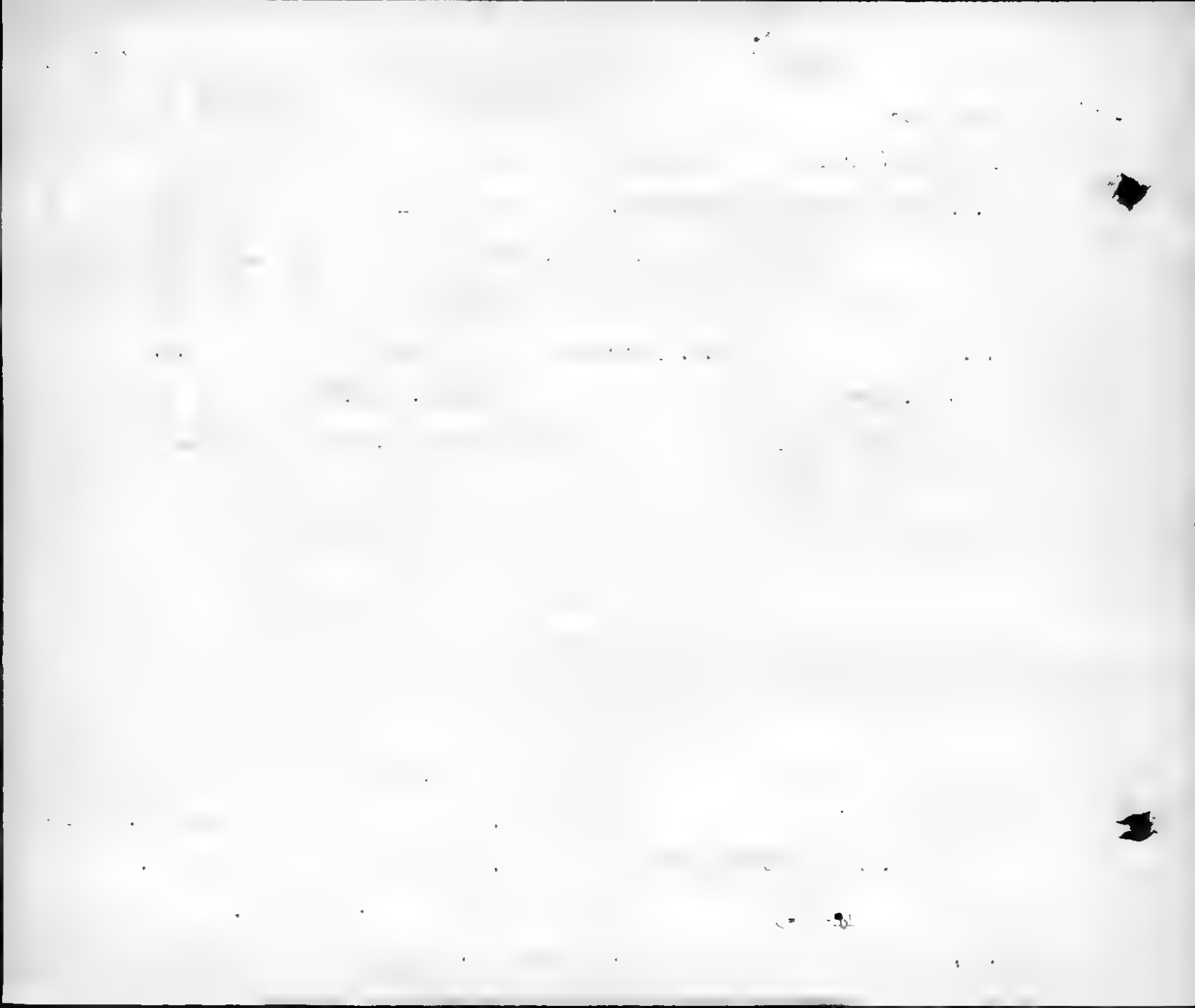
Reg. Dist. No. 21

13856

13910

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 71 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida b. COUNTY <input checked="" type="checkbox"/> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patrick Air Force Base d. STREET ADDRESS 1031 D ALA e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank Steffens GRAFF First Middle Last 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10-29-01 9. AGE (In years last birthday) 58 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government 11. BIRTHPLACE (State or foreign country) Kentucky 12. CITIZEN OF WHAT COUNTRY? U.S. 13. FATHER'S NAME Joseph H. GRAFF 14. MOTHER'S MAIDEN NAME Helen L. STEFFENS 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. WW I and II 17. INFORMANT (Wife) Mildred C. Graff Address Same as #2			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with metastasis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 6 October , 19 59 , to 16 December , 19 59 , that I last saw the deceased alive on 16 December , 19 59 , and that death occurred at 10:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 12-16-59 ACTUAL SIGNATURE Douglas R. Koth M.D. PHYSICIAN'S NAME (Type) D.R. KOTH LCDR MC USN U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12-18-59 22c. NAME OF CEMETERY OR CREMATORY Arlington National 22d. LOCATION (City, town, or county) (State) Arlington Va.		23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS 7557 Wisconsin Ave. Bethesda Md. 24a. REC'D BY REGISTRAR DEC 21 '59 DATE 24b. REGISTRAR'S SIGNATURE Arthur S. Hume					

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please use carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

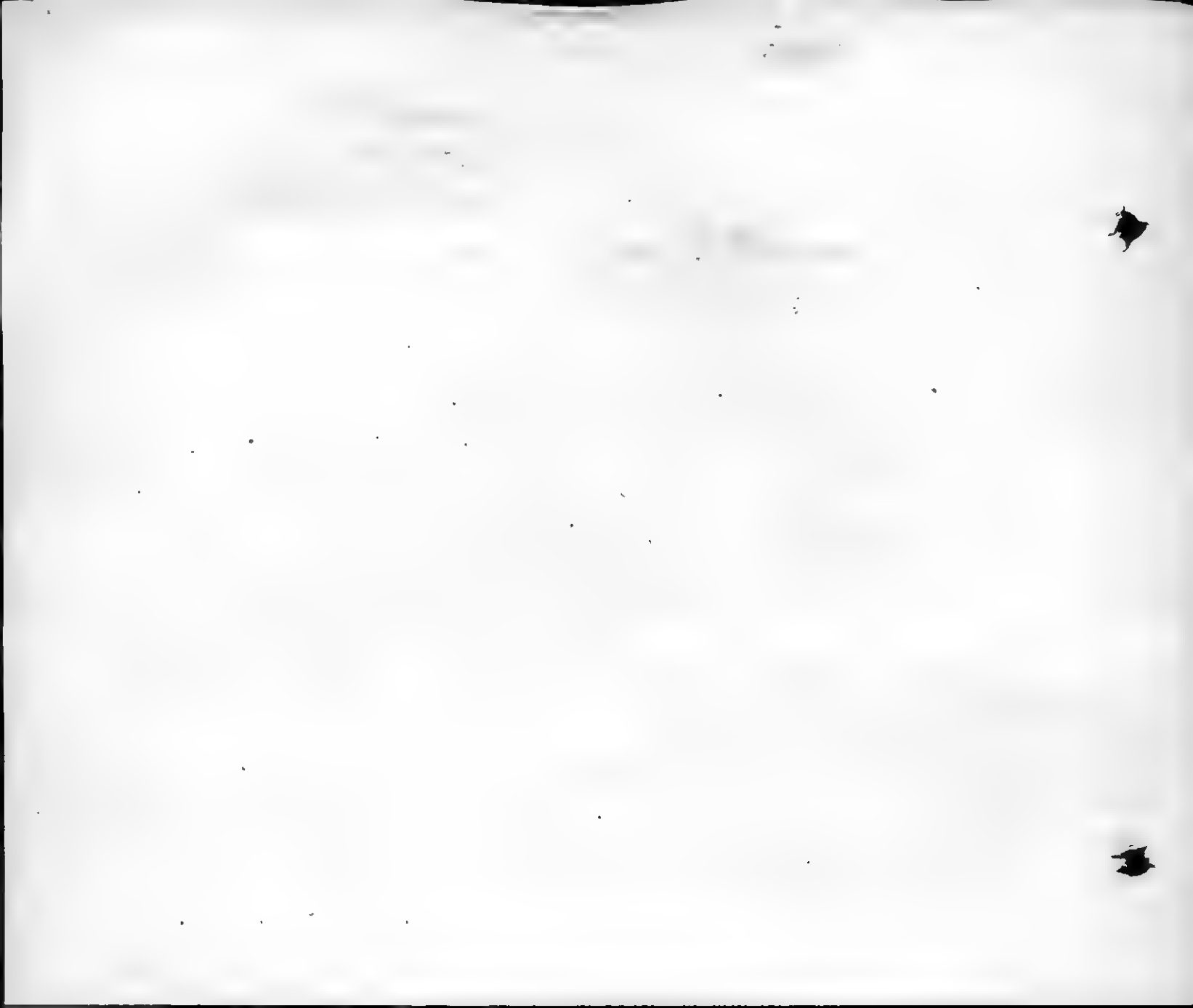
13835

CERTIFICATE OF DEATH

Reg. Dist. No.

13857

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>New Jersey</i> b. COUNTY?	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lakewood Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Summit</i>	
c. LENGTH OF STAY IN 1b <i>4 yrs 10 mo 5 days</i>		d. STREET ADDRESS <i>Suburban Hotel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Washington Lane Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>E. Norma R. Graham</i>		4. DATE OF DEATH <i>12 5 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-8-85</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Not known by Hosp.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>MARCUS PURCELL</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Proctor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>not Chart of Wash Lane Hosp.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Accident</i> DUE TO (b) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1-day</i> <i>? years</i> <i>? years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1956</i> to <i>12-5-59</i> , that I last saw the deceased alive on <i>12-2-59</i> , and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Hare</i>		ADDRESS (Street, city or town, state) <i>7600 Carroll Ave., Tak. Park, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Robert A. Hare</i>		DATE SIGNED <i>12/5/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		22b. DATE THEREOF <i>12/9/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Jackson Memorial Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Lexington, Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S.H. Hines co</i>		24a. REC'D BY REGISTRAR <i>2901-14 St. N. W.</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		DATE DEC 8 '59	



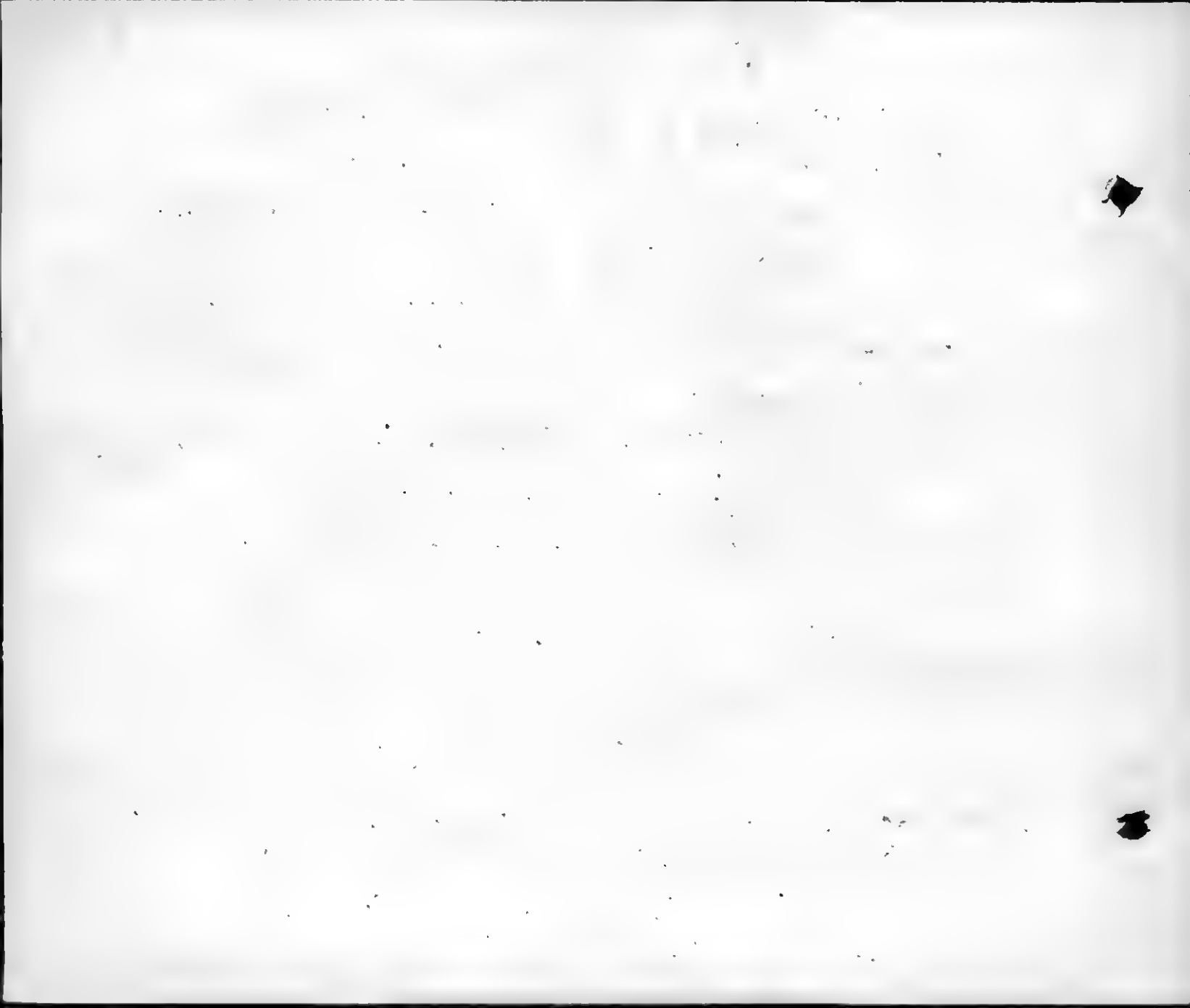
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13911
CERTIFICATE OF DEATH

13858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Wheaton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>13502 Grenoble Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NANCY JANE GRANZOW</u>				4. DATE OF DEATH Month Day Year <u>12 4 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 18 1921</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK O. Shrodes</u>				14. MOTHER'S MAIDEN NAME <u>ETHEL McCARTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-18-7615</u>		INFORMANT Address <u>Richard GRANZOW Husband same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1. xx</u> <u>Circulatory system</u>							<u>Several</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO (b) <u>Staphylococcus aureus - Left Breast</u>							<u>6 wks 9 hrs</u>
DUE TO (c) <u>Radiation pneumonia left lung</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-11</u> , 19 <u>58</u> , to <u>12-4</u> , 19 <u>59</u> that I last saw the deceased alive on <u>12-4</u> , 19 <u>59</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah E. Glover</u> M.D. <u>10128 CEDAR LAKE NEWSINGTON, MD</u>						DATE SIGNED <u>12-5-59</u>	
PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fork Lissen</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u> ADDRESS <u>Mt. Rainier Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasa</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

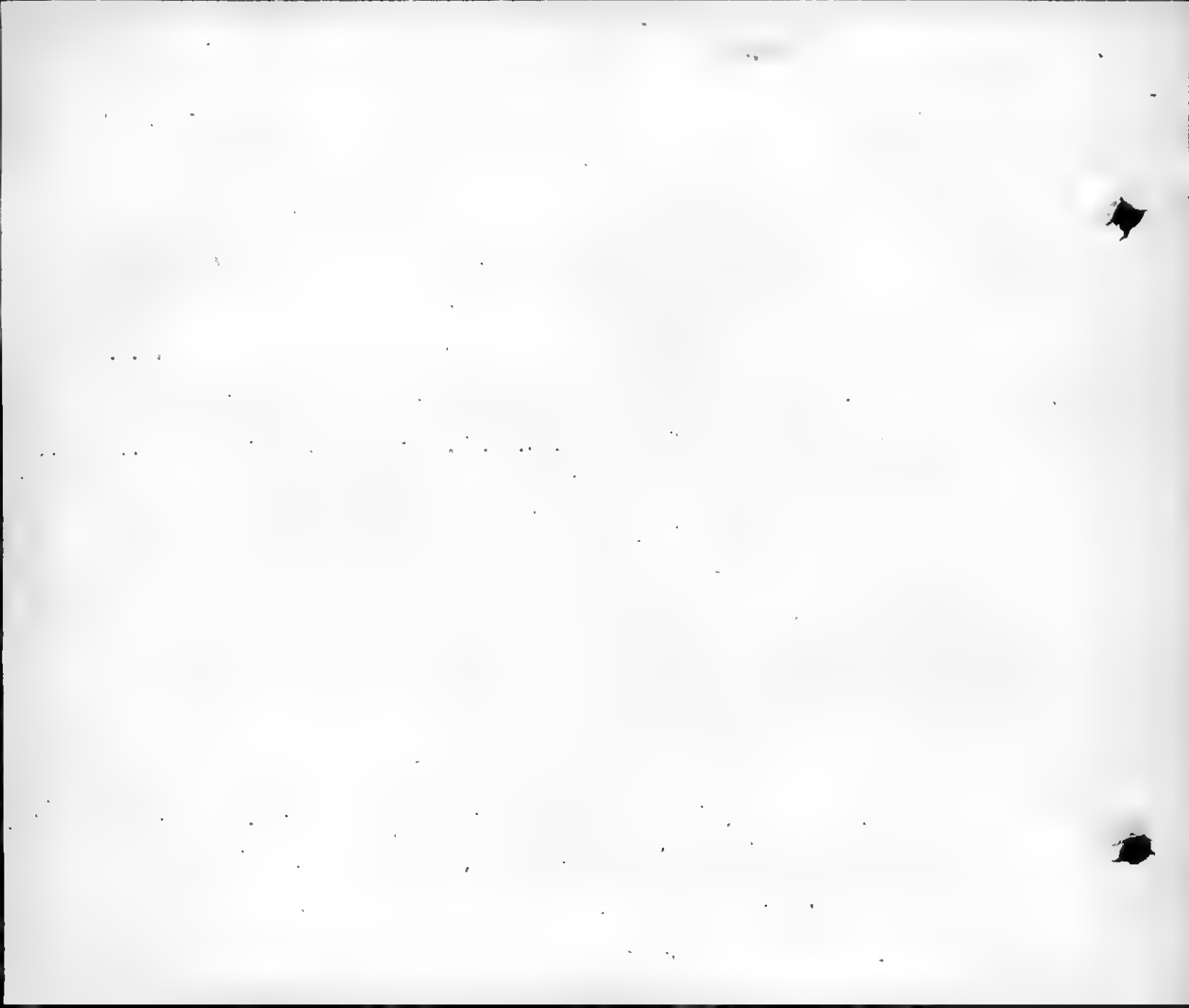
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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13912
CERTIFICATE OF DEATH

13859

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Perry Last Griffith		4. DATE OF DEATH Month 12 Day 10 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/79
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 9 Days 23 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard H. Perry		14. MOTHER'S MAIDEN NAME XXXXX Margaret Waters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. ADDRESS Mrs. J. H. Littlepage, 8612 Ridge Rd., Beth.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cerebrovascular Accident 331X DUE TO (b) cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 5, 19 59 to Dec. 10, 19 59 , that I last saw the deceased alive on Dec. 10, 19 59 , and that death occurred at 2:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George A. Gray, Jr.		DATE SIGNED 12/10/59	
PHYSICIAN'S NAME (Type) George A. GRAY, Jr. M.D.		ADDRESS 4422 East-West Hwy, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-59	
22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE DEC 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13836

CERTIFICATE OF DEATH

13860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE DISTRICT OF COLUMBIA b. COUNTY 47x-1 ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK, MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, DISTRICT OF COLUMBIA	
d. NAME OF HOSPITAL (If not in hospital, give street address) 700-HUDSON AVENUE-EVENTIDE NURSING HOME		d. STREET ADDRESS 615-UNDERWOOD STREET, N.W.	
3. NAME OF DECEASED (Type or print) First DORA Middle M. Last HAACK		4. DATE OF DEATH Month DECEMBER Day 19th Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 30, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 19 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - AT HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Brasa		14. MOTHER'S MAIDEN NAME Doris Elhardt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MR. FRED J. HAACK		Address WASHINGTON, D.C. 615-UNDERWOOD ST, N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiac disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 10 min 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1952 , to Dec 19, 1959 , that I last saw the deceased alive on Dec 8, 1959 , and that death occurred at 4:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M.F. OTTMAN		ADDRESS (Street, city or town, state) 441 Kennedy St NW Wash DC DATE SIGNED 12/20/59	
PHYSICIAN'S NAME (Type) M.F. OTTMAN		401-KENNEDY STREET, N.W.-WASH. D.C. 12/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-22-59	22c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSO		COMPANY 1300-N. ST, N.W.-WASHINGTON, D.C.	
24a. REC'D BY REGISTRAR DATE DEC 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

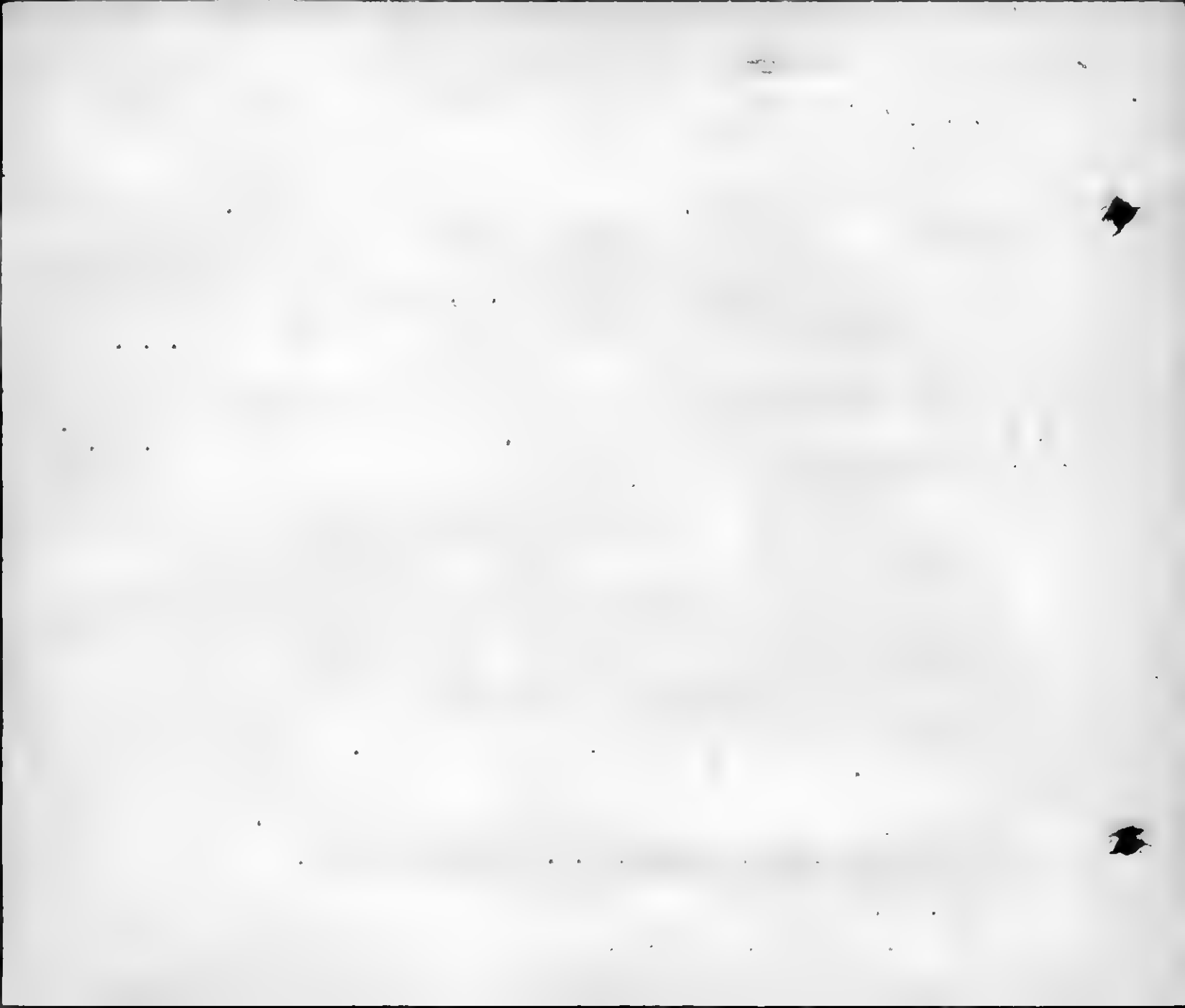
13913

CERTIFICATE OF DEATH

Reg. Dist. No. 13861

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 12 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4005 Underwood St.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
				d. STREET ADDRESS 4005 Underwood St.			
3. NAME OF DECEASED (Type or print) First Dora Middle Albaugh Last Hale				4. DATE OF DEATH Month December Day 27 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1862	9. AGE (In years last birthday) 97 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Albaugh				14. MOTHER'S MAIDEN NAME Priscilla Mendenhall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Sarah Sutton Address 4005 Underwood St. Chevy Chase, Md.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Chronic myocarditis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 days Over 30 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 21, 1947 to Dec. 27, 1959 , that I last saw the deceased alive on Dec. 27, 1959 , and that death occurred at 12:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Katharine A. Chapman M.D. 3924 Baltimore St.							
PHYSICIAN'S NAME (Type) Katharine A. Chapman, M.D. Kensington, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Trans. Bur.		22b. DATE THEREOF 12/29/59		22c. NAME OF CEMETERY OR CREMATORY West Milton cemetery		22d. LOCATION (City, town, or county) (State) West Milton, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. RECEIVED BY REGISTRAR DEC 30 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

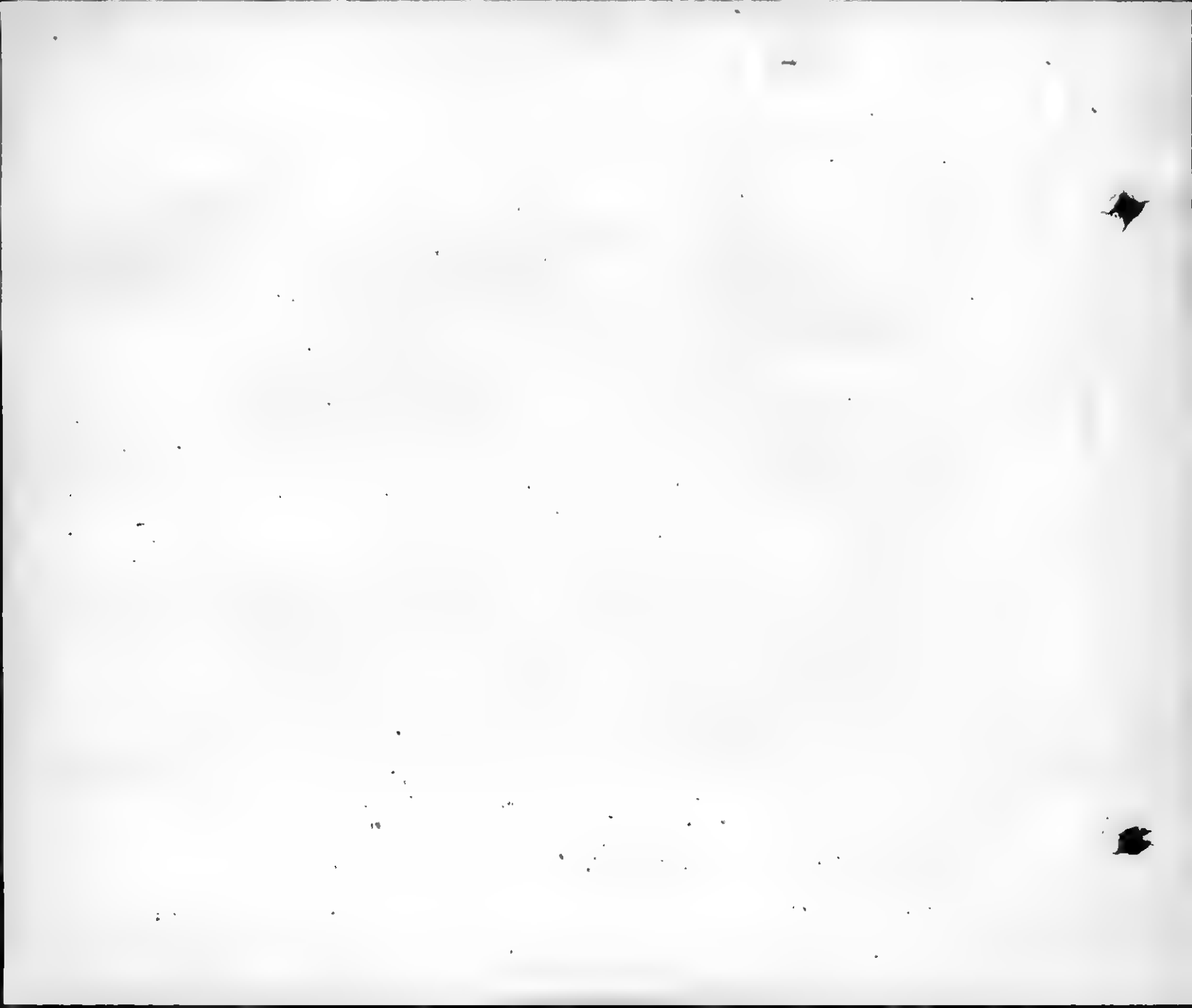
13914

CERTIFICATE OF DEATH

Reg. Dist. No.

13862

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>15919 ANNISTON ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lilian</u> Middle <u>DEARY</u> Last <u>HAMILTON</u>				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3-21-1901</u>	
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BRITISH EMBASSY</u>		11. BIRTHPLACE (State or foreign country) <u>LONDON, ENGLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>CANADA</u>							
13. FATHER'S NAME <u>HENRY DEARY ROSS</u>				14. MOTHER'S MAIDEN NAME <u>LILLIAN CATHARINE GODFREY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT (Name) <u>SHIRLEY D. TANNER</u>				Address <u>BETHESDA 5919 ANNISTON RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized carcinoma metastatic to liver.</u> <u>153.0</u> DUE TO <u>Carcinoma of Cecum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>3 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1954</u> to <u>December 7, 1959</u> , that I last saw the deceased alive on <u>December 7, 1959</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Roger Kurtz, M.D.</u>				ADDRESS (Street, city or town, state) <u>3701 Conn Ave. NW, Wash 8, D.C.</u> DATE SIGNED <u>12-7-59</u>			
PHYSICIAN'S NAME (Type) <u>C. Roger Kurtz, M.D.</u>							
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Bur-Transit 12/11/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Hills Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Toronto, Canada</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 10 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13863

13915

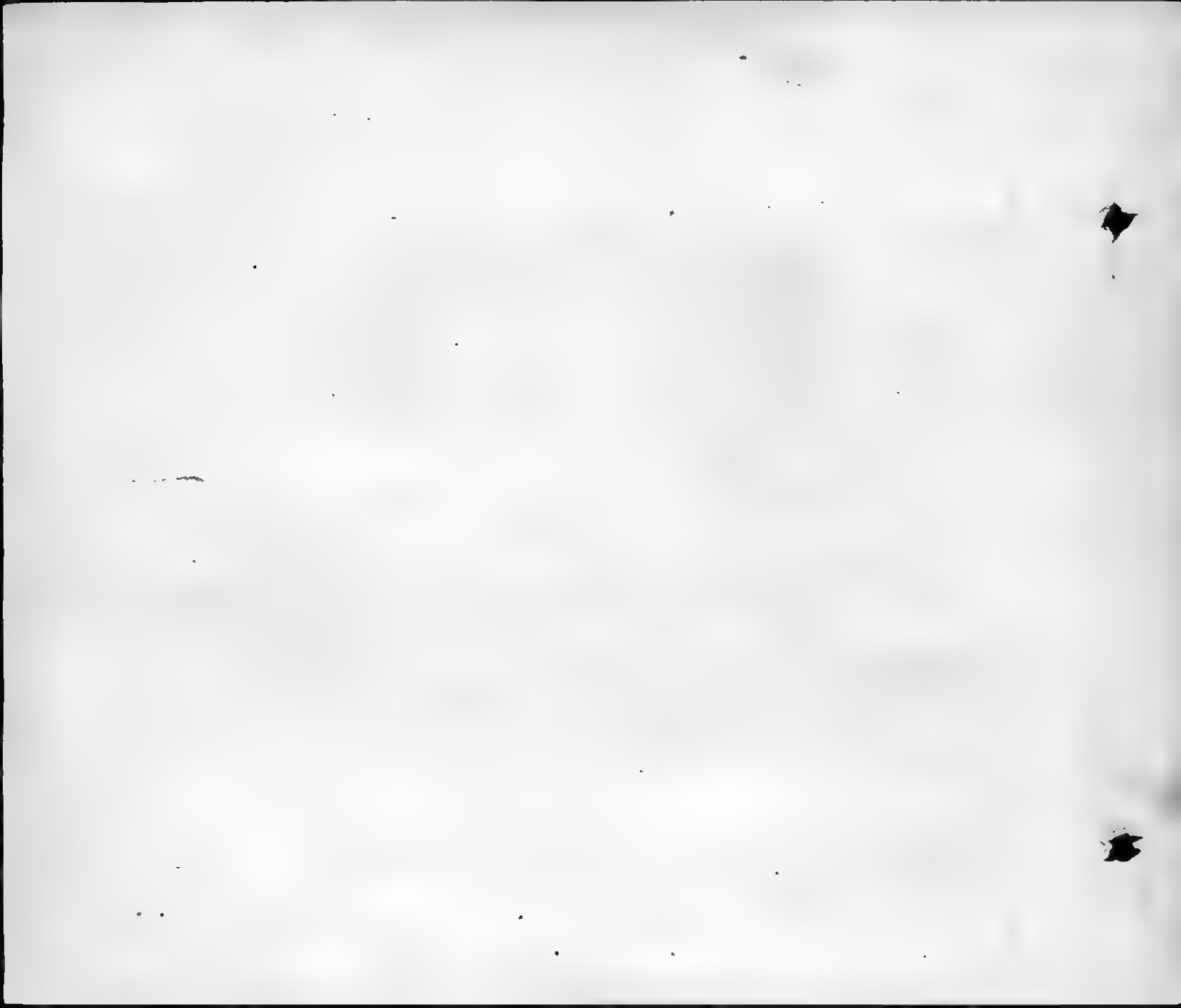
Item 7 File 10255 12-17-59 et

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Naval Hosp		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda Naval Hosp.		d. STREET ADDRESS 8 W. Jeffery Street	
3. NAME OF DECEASED (Type or print) Eddie Roy Harris		4. DATE OF DEATH Dec. 9 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/1907
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR 3 Months 14 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Harris		14. MOTHER'S MAIDEN NAME Bessie Rogers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Family	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 min.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John G. Ball		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 9 Dec. 1959	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 12/13/59	
22c. NAME OF CEMETERY OR CREMATORY Oakwood Cem.		22d. LOCATION (City, town, or county) (State) Siler City, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes		ADDRESS 130 E. Fort Ave.	
24a. REC'D BY REGISTRAR DEC 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



13916

CERTIFICATE OF DEATH

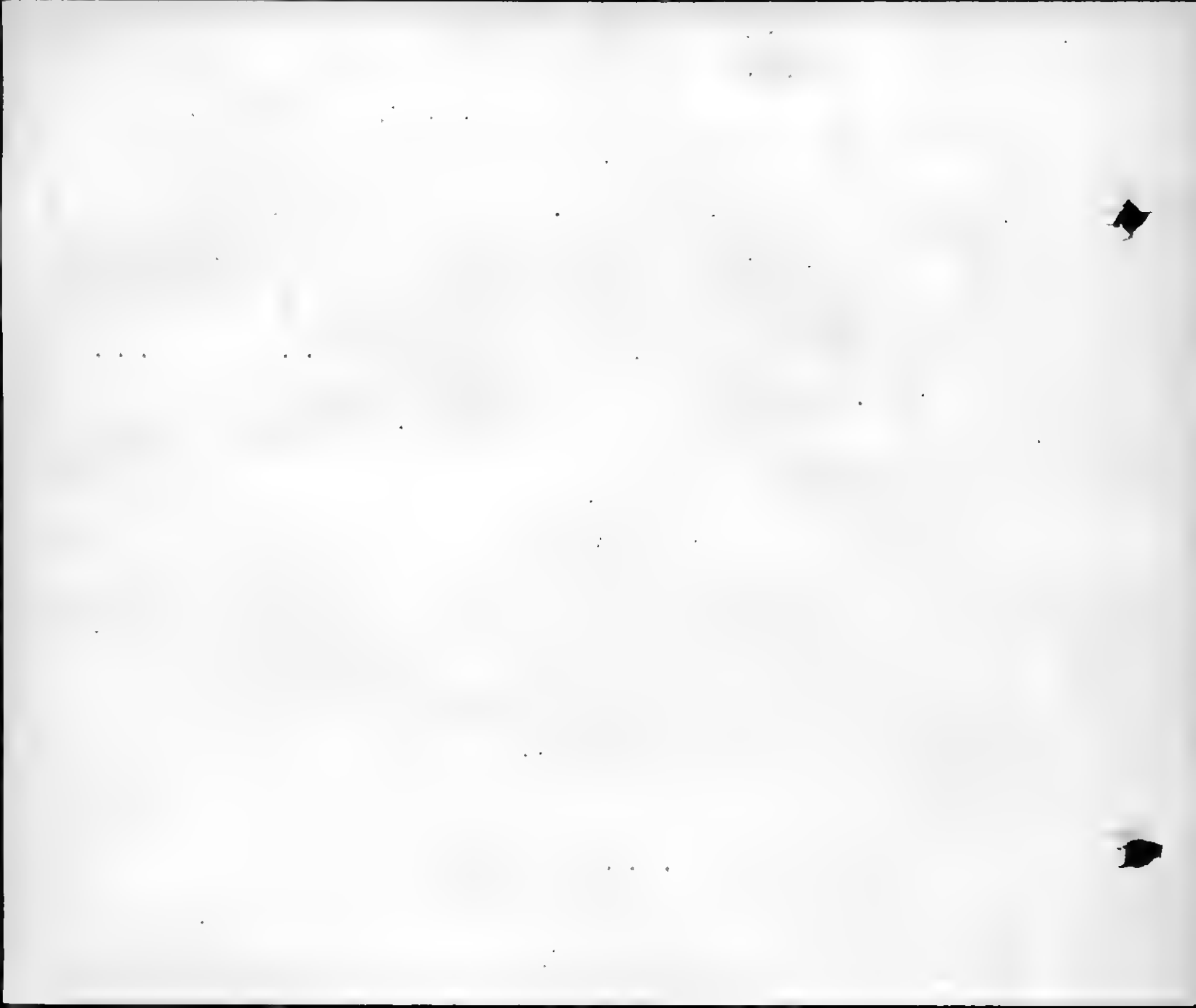
Reg. Dist. No.

13864

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>4916 35th Street, North</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Stone</u> Last <u>Haseltine</u>				4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 July 1947</u>	
9. AGE (In years lost birthday) <u>12</u> yrs		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min <u>12</u>		IF UNDER 24 HRS Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min <u>12</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Nathan S. Haseltine</u>				14. MOTHER'S MAIDEN NAME <u>Emily Clevonger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
INFORMANT Address <u>The Medical Record</u> <u>The Clinical Center, Bethesda 14, Maryland</u>							
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>							
224X DUE TO							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Pheochromocytoma</u>							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>November 4, 1959</u> , to <u>December 1, 1959</u> , that I last saw the deceased alive on <u>December 1, 1959</u> , and that death occurred at <u>4:50 PM</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>12/1/59</u>							
ACTUAL SIGNATURE <u>Louis Gillespie Jr.</u>				M.D. <u>The Clinical Center</u>			
PHYSICIAN'S NAME (Type) <u>Louis Gillespie Jr. M.D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>12-4-59</u>		<u>Cedar Hill Crematory</u>		<u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ives Funeral Home</u> By: <u>C.M. Travel</u>				ADDRESS <u>2847 Wilson Blvd., Arlington, Va.</u>			
24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

13865

13917

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE District of Columbia D. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 319 days		d. STREET ADDRESS 3133 Conn. Ave. Kennedy/Apt.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3 NAME OF DECEASED (Type or print) First Mary Middle Martha Last HECK		4. DATE OF DEATH Month December Day 6 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-25-94
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR Months 4 Days 7	IF UNDER 24 HRS Hours 12 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	

13. FATHER'S NAME John HECK		14. MOTHER'S MAIDEN NAME Sarah LOGUE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. WW II	
INFORMANT (Sister) Elsie H. Eleder		Address 2201 Echodale Ave Baltimore, Md.	

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, breast - generalized metastases 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

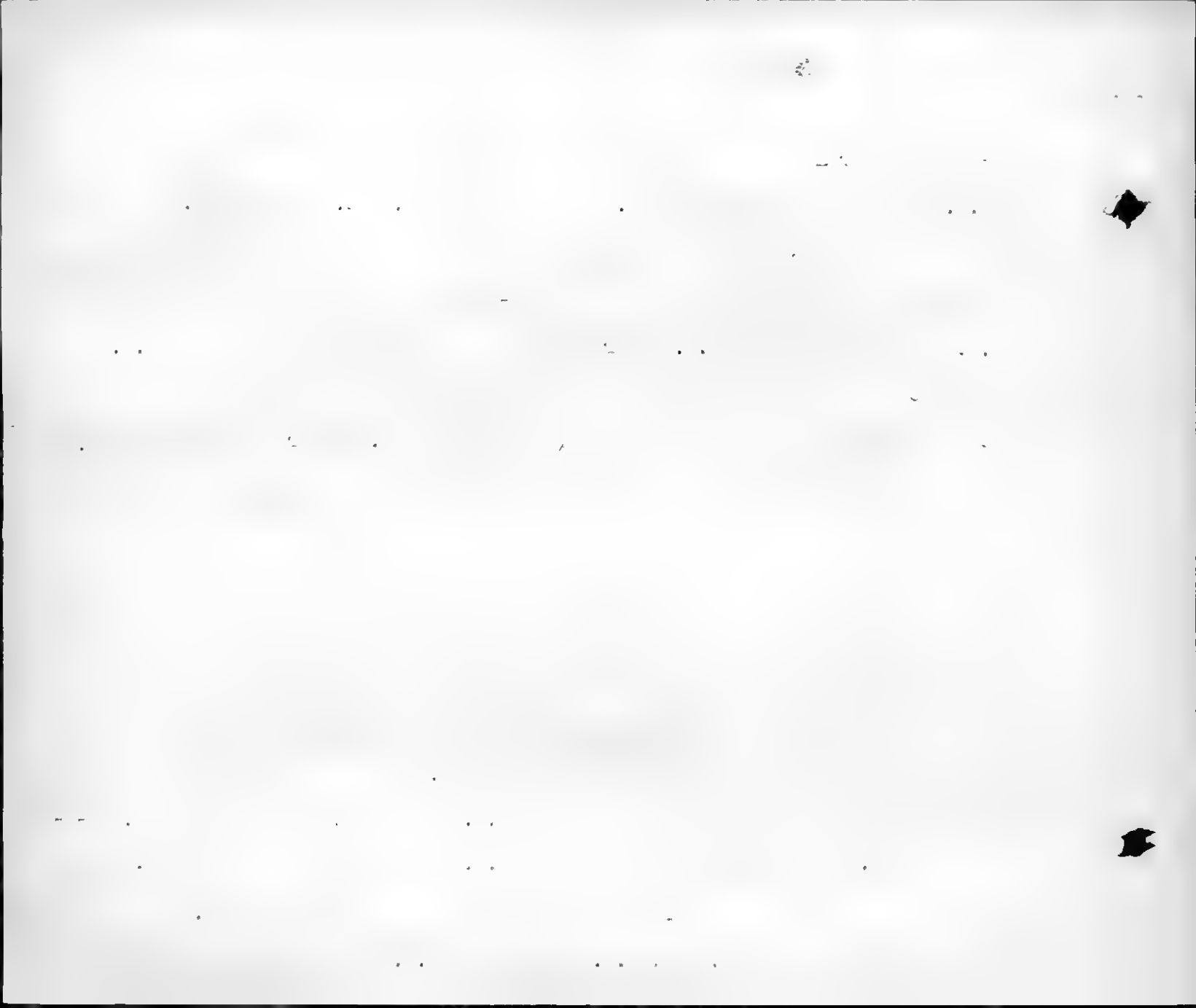
21. I certify that I attended the deceased from 21 January , 19 59 , to 6 December , 19 59 that I last saw the deceased alive on 6 December , 19 59 and that death occurred at 5:06 M, from the causes and on the date stated above.		DATE SIGNED
ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>[Signature]</i>	M.D. U.S. Naval Hospital, Bethesda Md. 12-7-59	
PHYSICIAN'S NAME (Type) D.P. OSBORNE CAPT MC USN	U.S. Naval Hospital, Bethesda Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-9-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Va.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gawlers</i> Joseph Gawlers 1756 Penn. Ave. N.W. Washington, D.C.		24a. REC'D BY REGISTRAR DEC 9 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13918

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13866

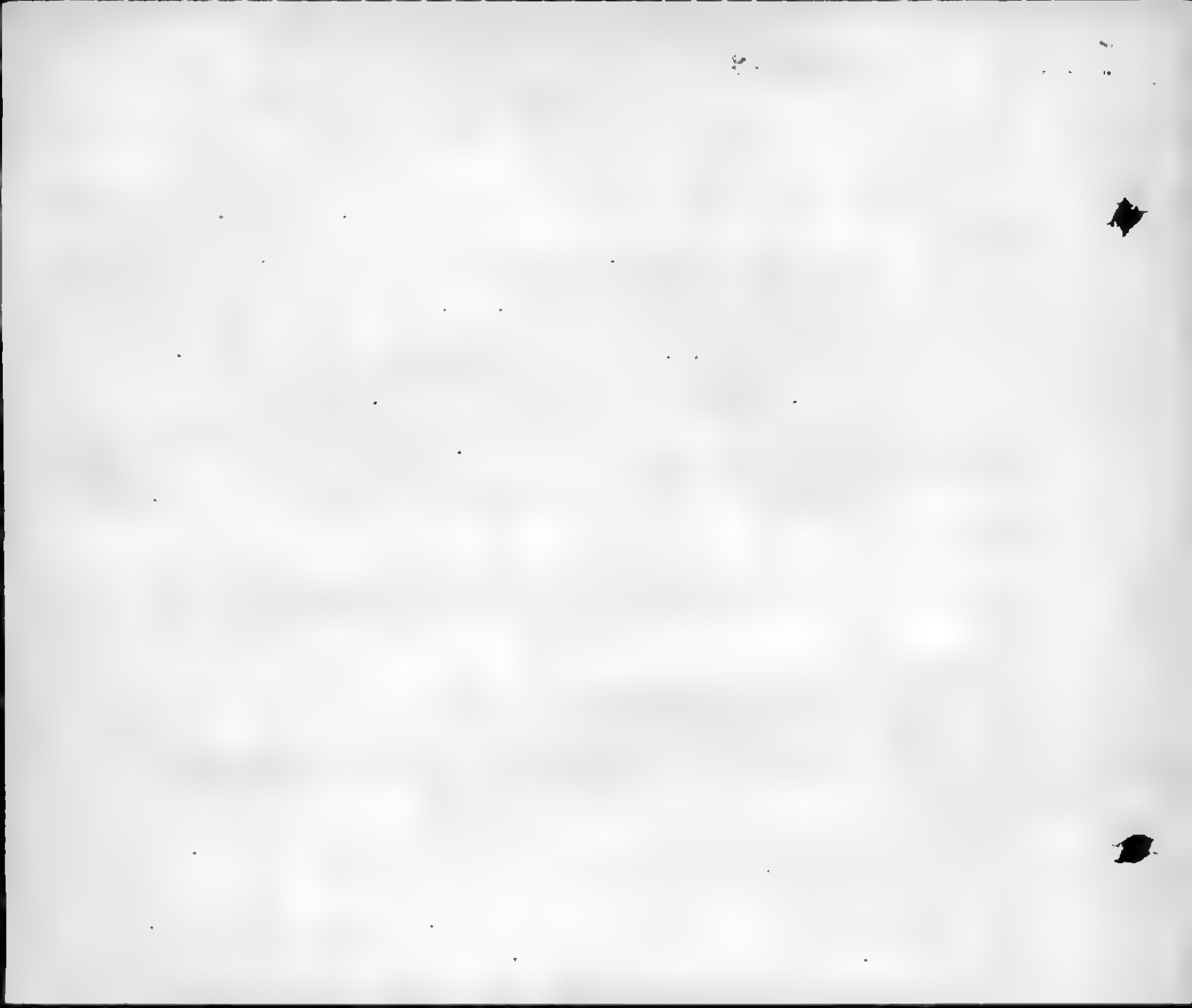
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8300 Tilbury Street		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8300 Tilbury St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HAROLD C. HEIGHAM		4. DATE OF DEATH Dec. 3, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1904
9. AGE (in years last birthday) 55 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME William H. Heigham	
14. MOTHER'S MAIDEN NAME Ella A. Ittner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Wife Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-5-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR DEC 7 1959	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

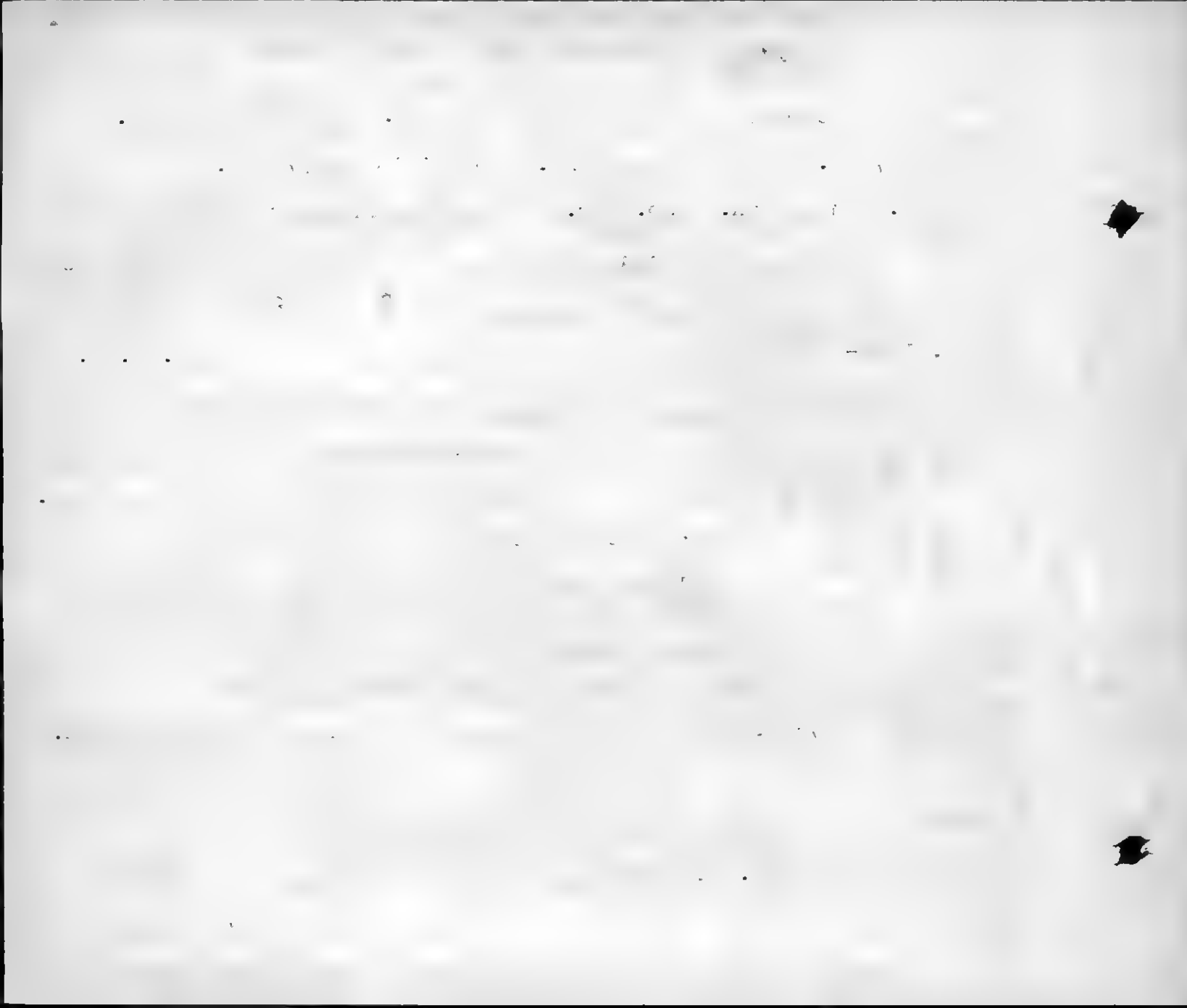
13867

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Md. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney, Md.		c. LENGTH OF STAY IN 1b 11½ hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. County Gen. Hosp. Inc.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.	
3. NAME OF DECEASED (Type or print) First Herman Middle August Last Heine		4. DATE OF DEATH Month 12 Day 18 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/87
9. AGE (1. years last birt. day) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 18 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. Clerk-retired		10b. KIND OF BUSINESS OR INDUSTRY Illinois	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gotleib Heine		14. MOTHER'S MAIDEN NAME Pauline Hoffman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Thoracic hemorrhage (c) Crushed chest DUE TO cause lost.			INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driver of car involved in auto accident			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in auto accident	
20c. TIME OF INJURY Month, Day, Year 2:52 p. m. 12, 17, 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Highway	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fulton Howard Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 12/18/59	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Dec 21, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George's Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		24a. RECEIVED BY REGISTRAR DEC 21 '59	
ADDRESS 254 Carroll St NW DC		24b. REGISTRAR'S SIGNATURE Cedric S. Harris	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13920

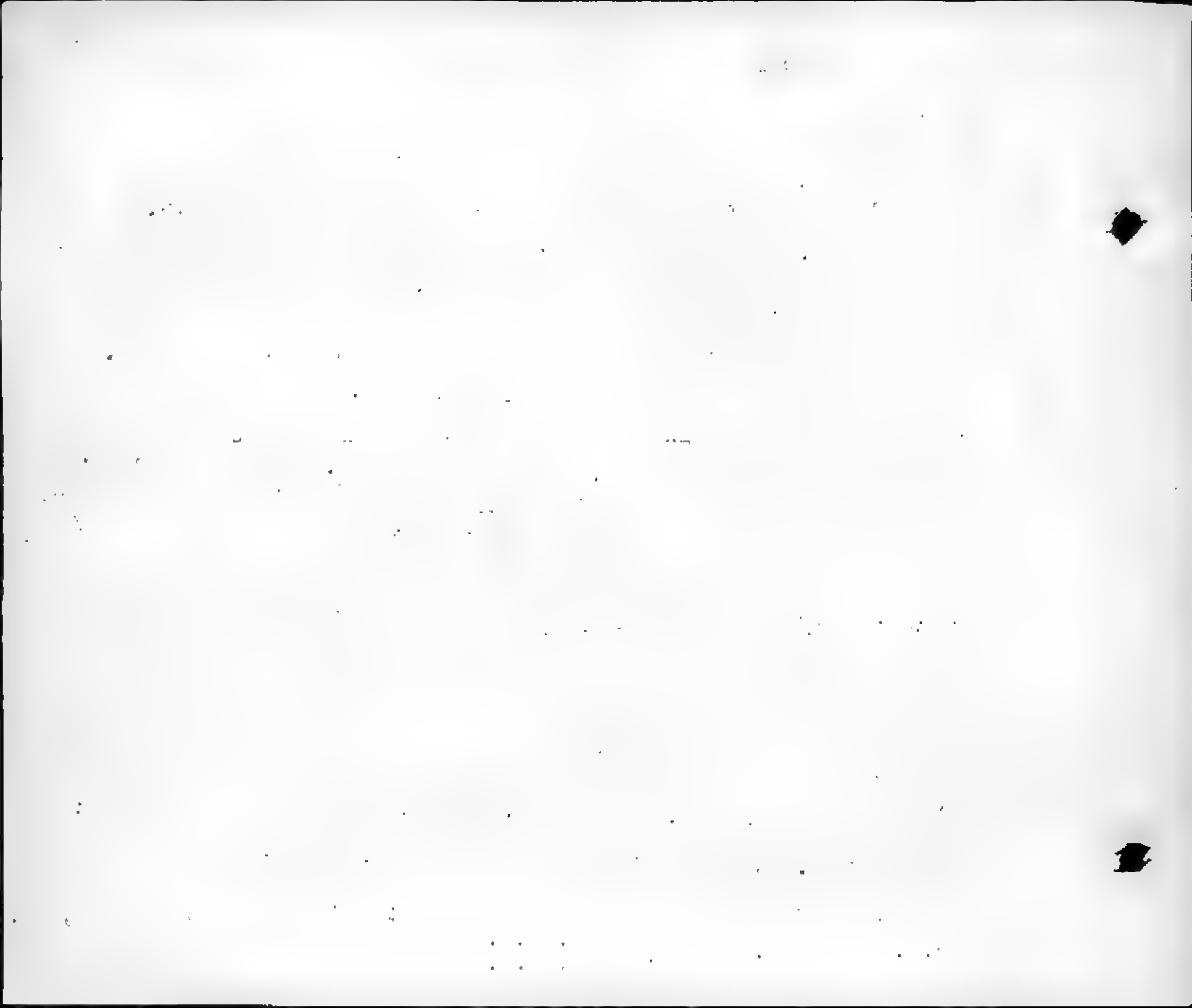
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE DC b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 4" X 3"	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9301 Weaver Street The Althea Woodland Nursing Home		d. STREET ADDRESS 1661 Harvard Street, N.W.	
3. NAME OF DECEASED (Type or print) First Milton Middle Herman Last Herman		4. DATE OF DEATH Month Dec Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/79
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min. 80	11. IF UNDER 24 HRS Months 80 Days 80 Hours 80 Min. 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Operator		10b. KIND OF BUSINESS OR INDUSTRY Ladies Wear	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Herman		14. MOTHER'S MAIDEN NAME Amelia Fishman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ***	
INFORMANT Home Records - 9301 Weaver Street		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 221X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) several years (c) several years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Former Hemiplegia Oct 1958			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1959 to Dec 9 1959 , that I last saw the deceased alive on Dec 8 1959 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John N. Andrews		DATE SIGNED Dec 9-59	
PHYSICIAN'S NAME (Type) John N. Andrews		ADDRESS (Street, city or town, state) 9601 Colesville Rd Silver Spring Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12/9/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE DEC 10 1959	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13863

13837

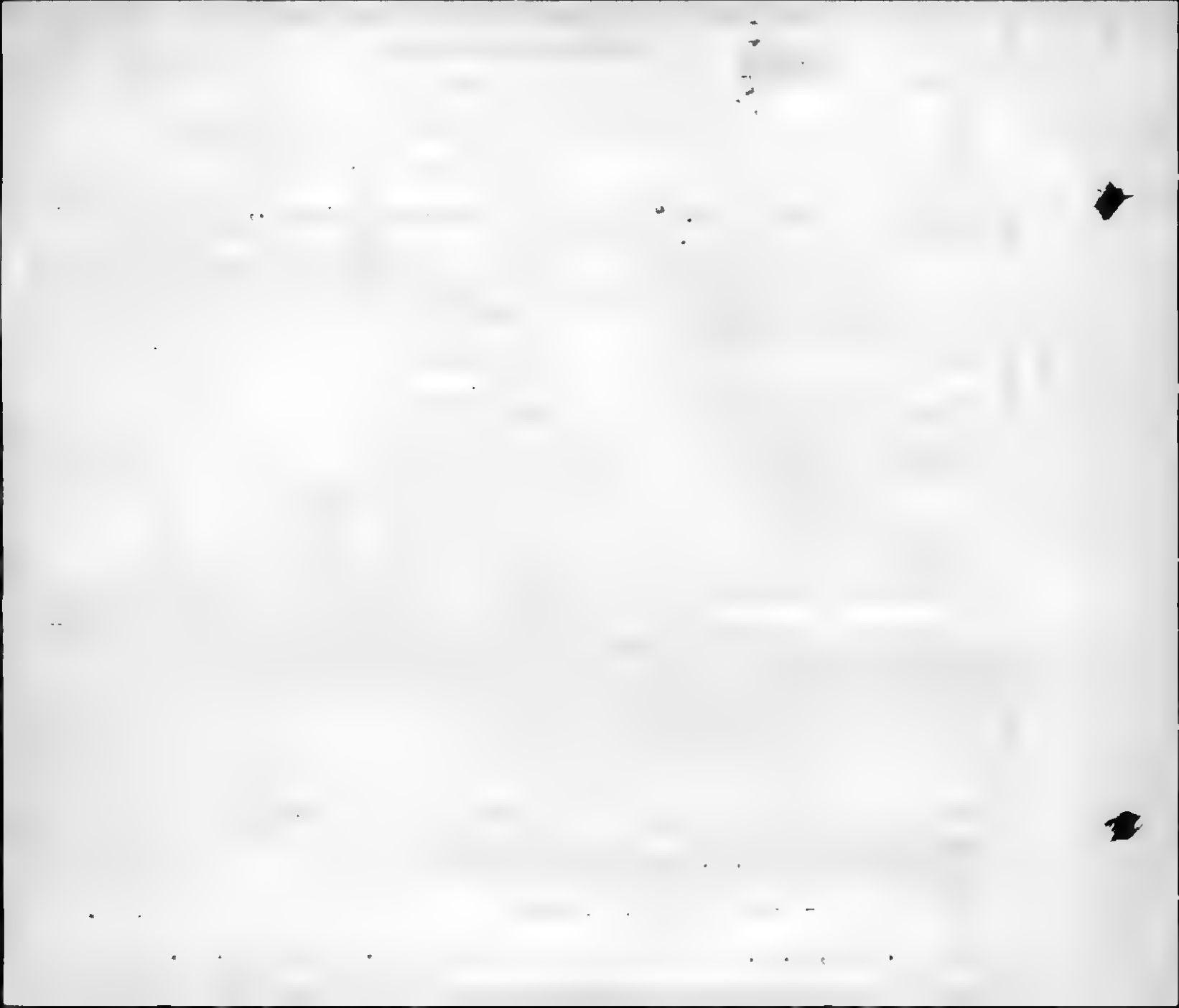
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>8625 Piney Branch Rd.,</u>	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year	
<u>Hester</u>		<u>12 13 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13 59</u>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
<u>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none</u>		<u>10b. KIND OF BUSINESS OR INDUSTRY none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Hester, William C.</u>		14. MOTHER'S MAIDEN NAME <u>Hester Marian Louise</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - 23 weeks gestation</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9:25 AM, 1959</u> to <u>9:50 AM, 1959</u> , that I last saw the deceased alive on <u>12-13</u> , 1959, and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emma Hughes</u> M.D.		ADDRESS (Street, city or town, state) <u>Washington Sanitarium and Hospital</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Emma Hughes, M.D.</u>		<u>Washington Sanitarium and Hospital</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-14-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u>		ADDRESS <u>Washington Sanitarium and Hosp. Takoma Park, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

VS A15 (4)
15M 9/55

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DEC 16 '59

Charles S. Hines



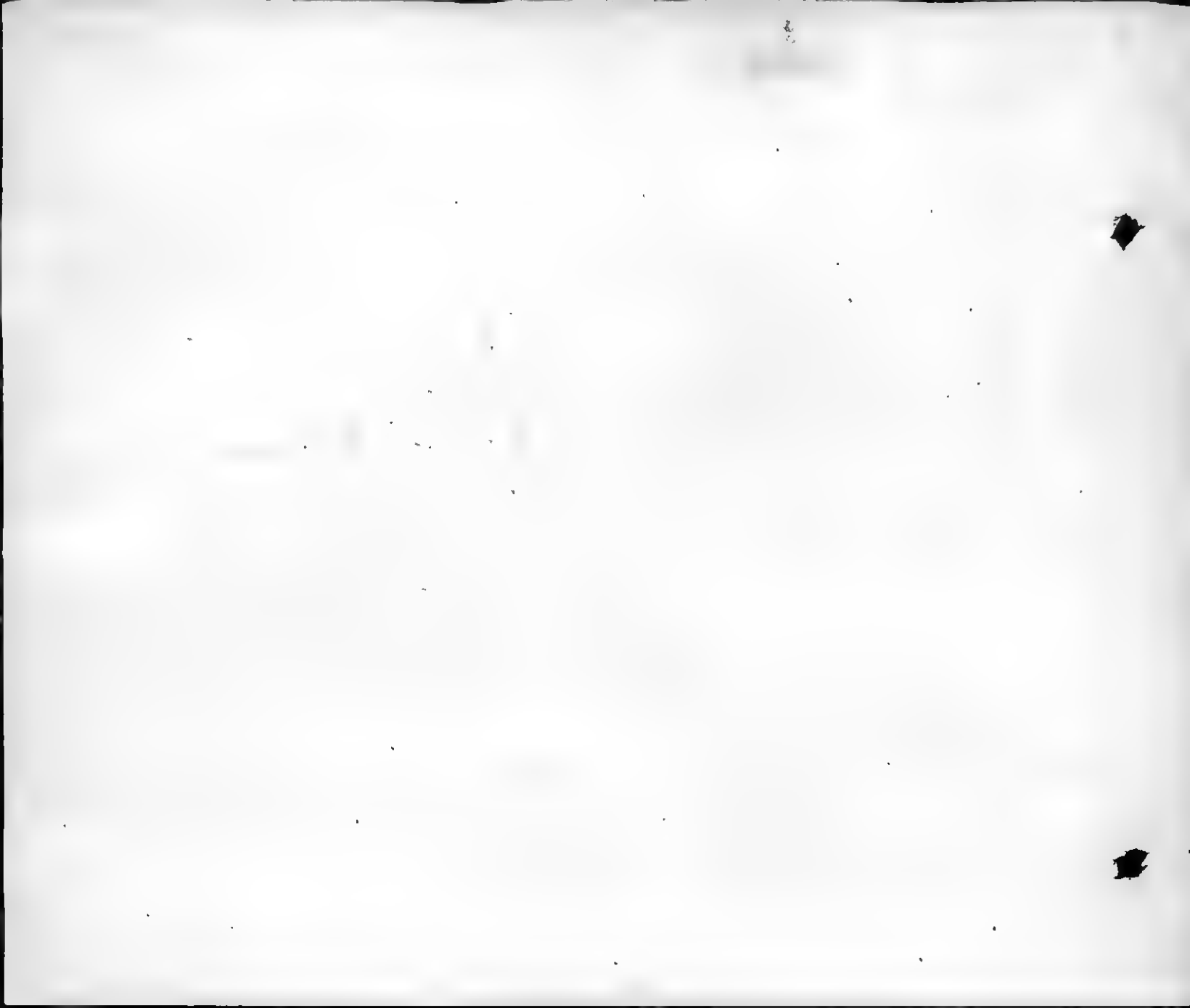
CERTIFICATE OF DEATH

Reg. Dist. No.

13870

13838

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Park c. LENGTH OF STAY IN lb 51 Hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Sanatorium & Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 12127 Georgia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Elizabeth Last Hoback		4. DATE OF DEATH Month 12 Day 1 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-12
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS Months 7 Days 1 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mountain Clerk		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry D. Spangler	
14. MOTHER'S MAIDEN NAME Lottie ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -	
16. SOCIAL SECURITY NO -		INFORMANT Hospital Records Address -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO essential hypertension gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Cerebral hemorrhage DUE TO pulmonary edema (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from September 1, 1957 , to Dec 1, 1959 , that I last saw the deceased alive on Dec 1, 1959 , and that death occurred at 11:30 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE Patrick C Jameson M.D.		ADDRESS (Street, city or town, state) 12020 Georgia DATE SIGNED 12/1/59	
PHYSICIAN'S NAME (Type) PATRICK C JAMESON		Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/5/59	22c. NAME OF CEMETERY OR CREMATORY Green Hill	22d. LOCATION (City, town, or county) (State) Waynesboro Franklin Co., Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove ADDRESS Waynesboro Pa		24a. REC'D BY REGISTRAR DEC 3 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Knead



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

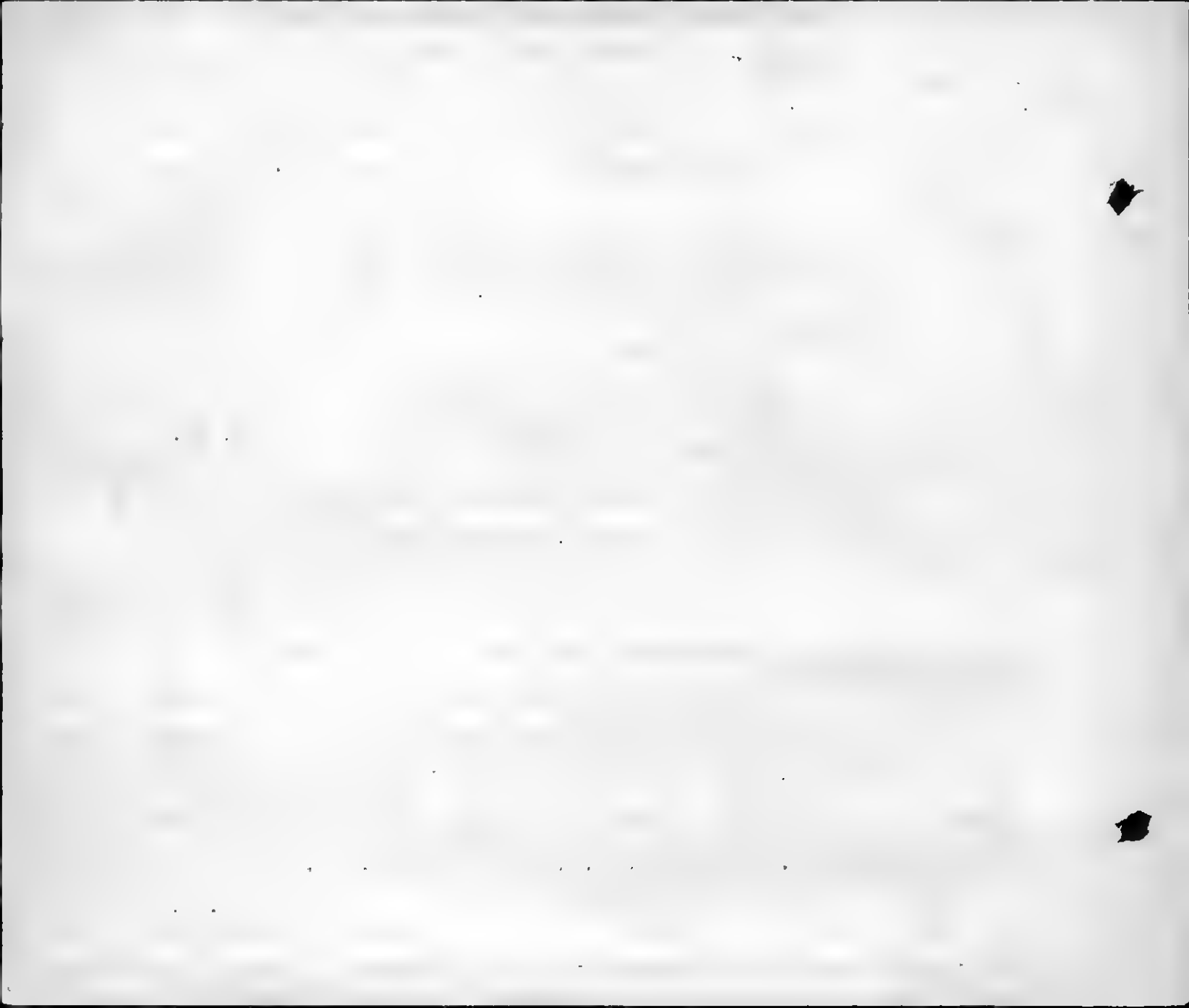
13871

13921

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,			c. LENGTH OF STAY IN 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Park, Md. 16 X		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home				d. STREET ADDRESS 4629 Davis avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MINNIE HOBBS				4. DATE OF DEATH Month December Day 21 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?	
9. AGE (In years last birthday) 80 ? yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none			
16. SOCIAL SECURITY NO. none				17. INFORMANT Maybell Gall Address Bradbury Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Hyper pyrexia, Unknown Cause DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hours 36 hours						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Nat white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 59 to Dec 20, 1959 , that I last saw the deceased alive on Dec 20 19 59 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord Street DATE SIGNED Dec 21, 1959							
ACTUAL SIGNATURE Robert T. Thibadeau M.D.				10609 Concord Street			
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.				Kensington, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/59		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE DEC 22 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13922

CERTIFICATE OF DEATH

Reg. Dist. No.

13872

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9806 Forest Grove Drive				d. STREET ADDRESS 9806 Forest Grove Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mattie Middle Lula Last Hodge				4. DATE OF DEATH Month December Day 31 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/>		8. DATE OF BIRTH Dec 17, 1878	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH-PLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Ivan Renfrow				14. MOTHER'S MAIDEN NAME Cora Ann Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. No			
INFORMANT Alga Hodge				Address 1601 Argonne Pl NW- DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) General arteriosclerosis DUE TO (c) 4-5 years.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-12 , 19 59 , to 12-31 , 19 59 , that I last saw the deceased alive on 12-30 , 19 59 , and that death occurred at 10:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W.B. Wardrop M.D.				ADDRESS (Street, city or town, state) 800 Pershing Drive Silver Spring, Md.			
DATE SIGNED 12/21/59							
PHYSICIAN'S NAME (Type) W.B. Wardrop							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 1/1/1960			
22c. NAME OF CEMETERY OR CREMATORY Maplewood				22d. LOCATION (City, town, or county) (State) Wilson, North Carolina			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.				24a. REC'D BY REGISTRAR DATE JAN 4 '60			
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13873

Reg. Dist. No.

13923

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Holland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monty Co. Gen. Hosp</u>				d. STREET ADDRESS <u>Heels Shop Rd</u>		e. IS RESIDENCE ON A FARM? <u>NO</u>	
3. NAME OF DECEASED (Type or print) First <u>Eli</u> Middle <u>Hottinger</u> Last <u></u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Landscape</u>		11. BIRTHPLACE (State or foreign country) <u>va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 32 6658</u>		17. INFORMANT <u>Brenda Hottinger</u>		Address <u>Stm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Coronary heart disease</u> (c) <u></u> DUE TO (a) <u></u> (b) <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-20-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Dec. 23 '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u>		22d. LOCATION (City, town, or county) (State) <u>Redland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u>				ADDRESS <u>Laytonsville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finkel</u>			

MEDICAL CERTIFICATION



13924

CERTIFICATE OF DEATH

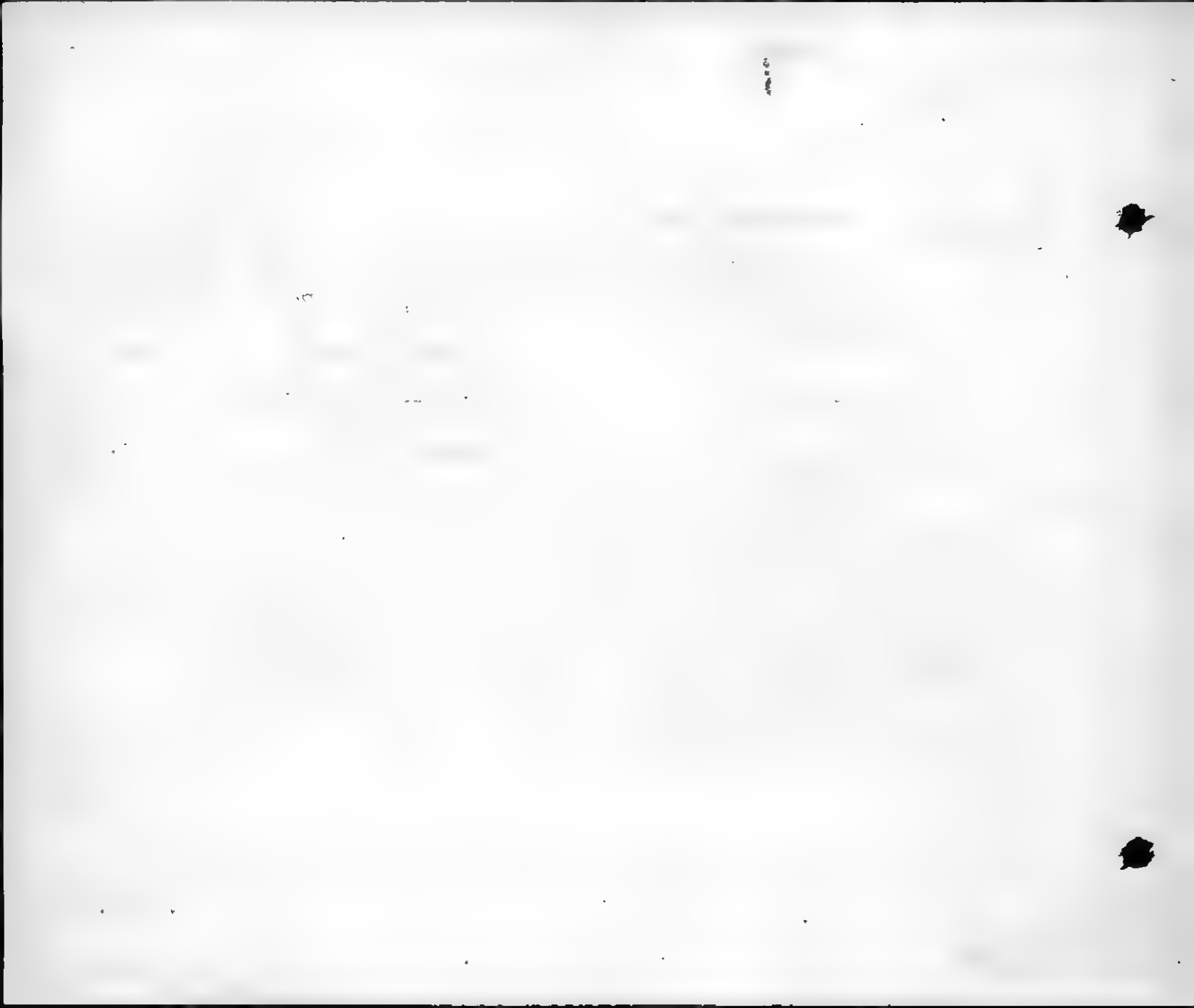
13874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSP				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FLORENCE VIRGINIA HOTTINGER				4. DATE OF DEATH DECEMBER 25 19 59			
5. SEX F. MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/2/ 1889	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME LEVI -Brady				14. MOTHER'S MAIDEN NAME SUSAN -- Whitecotton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO no			
17. INFORMANT HOSPITAL RECORDS Address OLNEY, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis (cerebral) DUE TO (b) Arteriosclerosis, generalized, severe DUE TO (c) ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, essential; Subacute urinary infection							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 1955 to December 25 1959 , that I last saw the deceased alive on Dec 25 , 19 59 , and that death occurred at 10:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DAMASCUS, MARYLAND DATE SIGNED 12/26/59							
ACTUAL SIGNATURE G.F. Meadors M.D.							
PHYSICIAN'S NAME (Type) G.F. MEADORS, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 29, 1959		22c. NAME OF CEMETERY OR CREMATORY Flower Hill		22d. LOCATION (City, town, or county) (State) Redland, Mont., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber ADDRESS Laytonsville, Md.				24a. REC'D BY REGISTRAR DEC 31 '59		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13839

CERTIFICATE OF DEATH

Reg. Dist. No. 13875

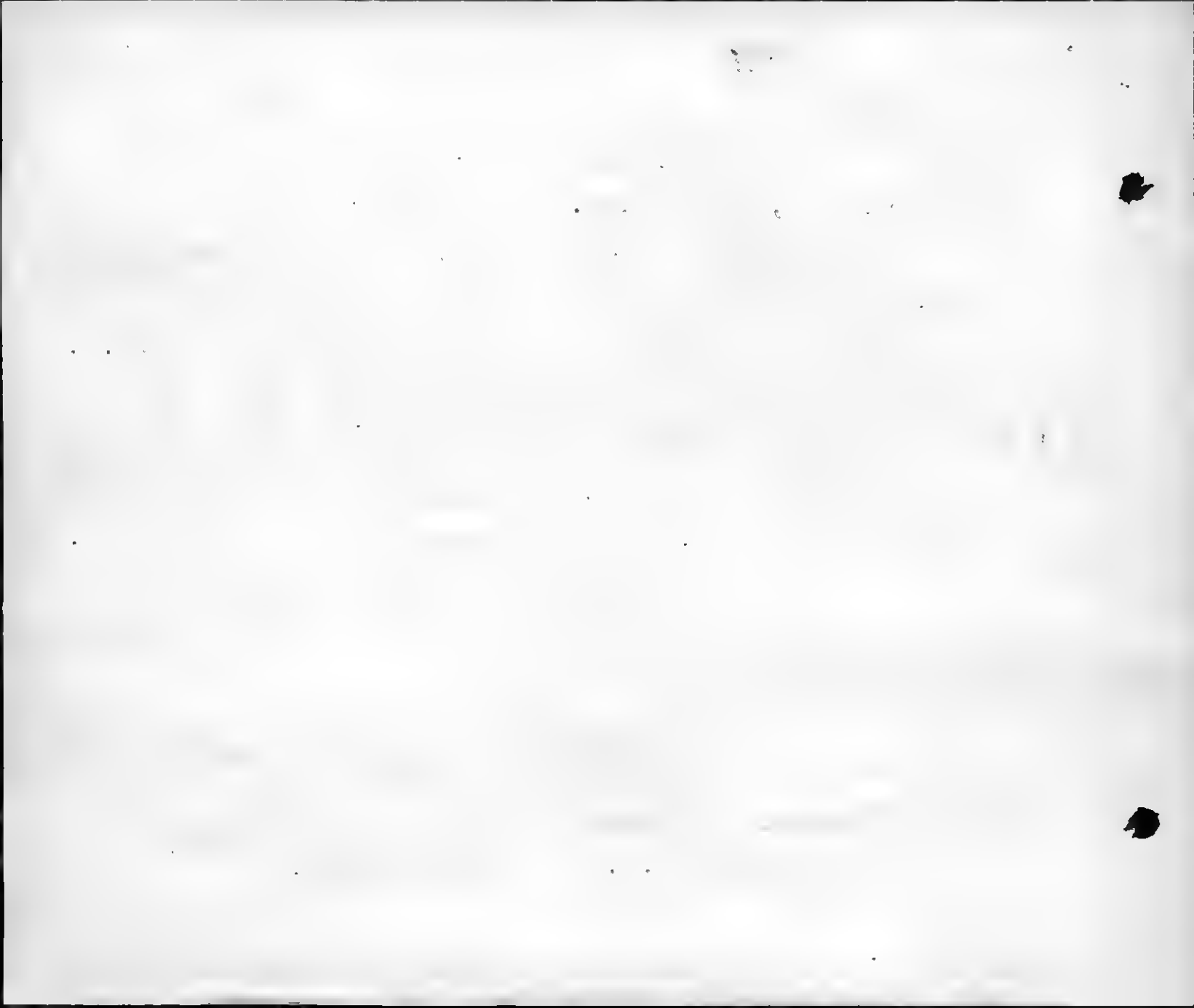
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mass. D.C.</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salem Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47X-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium & Hosp</i>		d. STREET ADDRESS <i>5427 Kansas Ave. NW</i>	
3. NAME OF DECEASED (Type or print) First <i>Harvey</i> Middle <i>Lee</i> Last <i>Howk Jr.</i>		4. DATE OF DEATH Month <i>12</i> Day <i>20</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-25-98</i>
9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Post Office Dept</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (State or foreign country) <i>Ill. Va</i>
12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>		13. FATHER'S NAME <i>Harvey Lee Howk</i>	
14. MOTHER'S MAIDEN NAME <i>Sarah Lemen</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>✓</i>	
16. SOCIAL SECURITY NO. <i>177X</i>		17. ADDRESS <i>pt Chap X</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of prostate</i> DUE TO (b) <i>177X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/12</i> 19 <i>47</i> to <i>12-20-59</i> 19 <i>59</i> , that I last saw the deceased alive on <i>12-20-59</i> , 19 <i>59</i> , and that death occurred at <i>7:44 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Arthur S. Kraus</i>		M.D. <i>113 Cassell St NW Wash DC</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-23-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul Joseph Horne</i>		ADDRESS <i>4812 G St NW DC</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE <i>DEC 28 '59</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 51 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4 Saint Agnes Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Okema		Middle May		Last Huffman		4. DATE OF DEATH Month December	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1951	
9. AGE (In years lost birthday) 8 yrs.		IF UNDER 1 YEAR Months 8		IF UNDER 24 HRS Days 23		Year 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Otuce Huffman				14. MOTHER'S MAIDEN NAME Orada Bostic			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 204.3		Gastro-intestinal Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 36 Hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Acute Lymphatic Leukemia				6 Mos.	
DUE TO		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 2, 1959 , to December 23, 1959 , that I last saw the deceased alive on December 23, 1959 , and that death occurred at 1:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles E. Mengel		M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 12-23-59	
PHYSICIAN'S NAME (Type) Charles E. Mengel, M.D.		National Institutes of Health Bethesda 14, Maryland					
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/59		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
				24b. REGISTRAR'S SIGNATURE Chas. S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13877

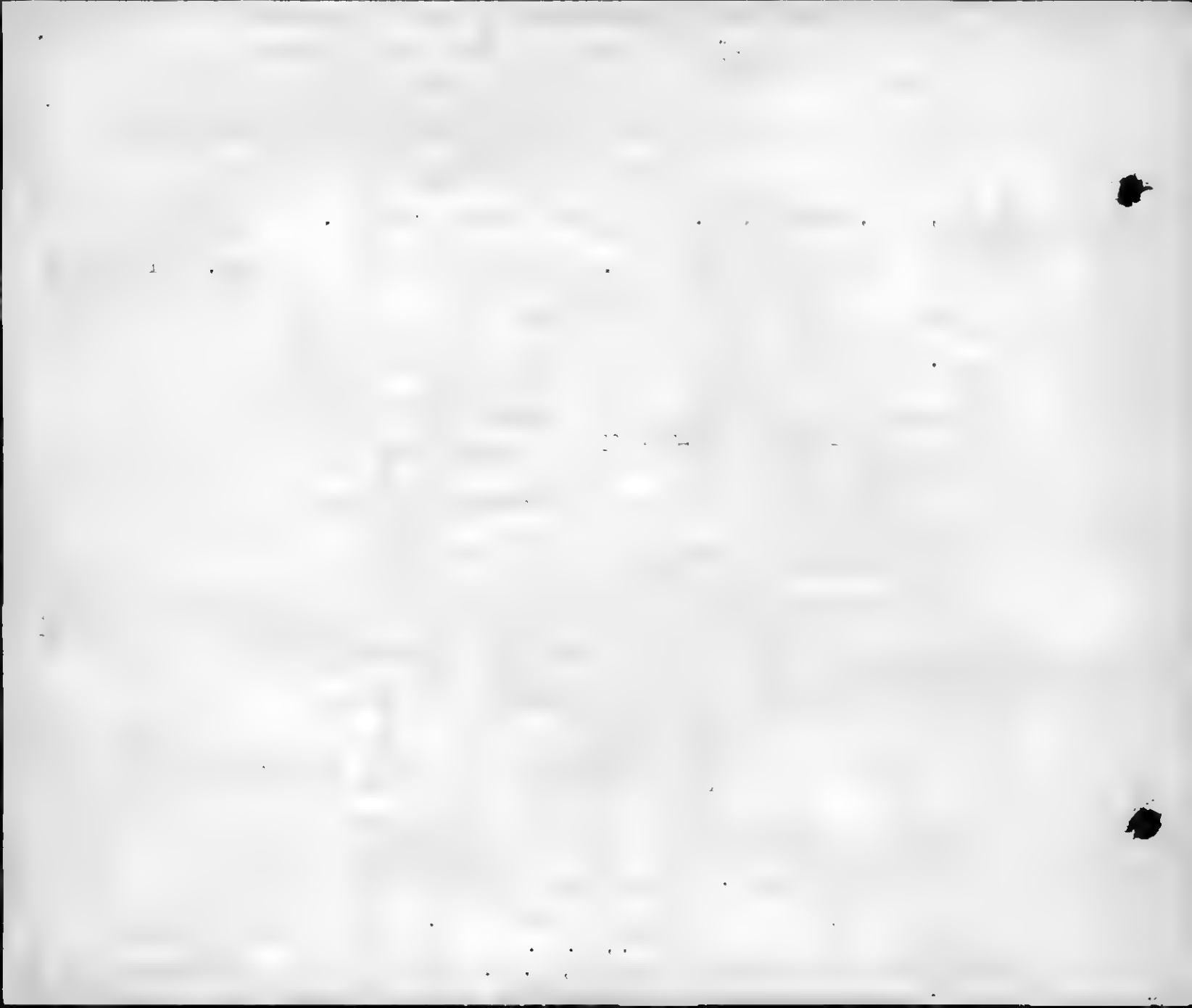
13926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>USNM, NMHC, BETHESDA, MD.</u>				d. STREET ADDRESS <u>6806 Greghy Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>L.</u> Last <u>HULLINGHORST</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>19 50</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEP-9-1916</u>		9. AGE (in years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col MC USA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U S Army</u>		11. BIRTHPLACE (State or foreign country) <u>TELA-HONDURAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE J HULLINGHORST</u>				14. MOTHER'S MAIDEN NAME <u>ROSA WARREN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1934-1959</u>		16. SOCIAL SECURITY NO. <u>212-38-8033</u>		17. INFORMANT Address <u>JEAN I HULLINGHORST</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brochart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Michael J. Rinaldi</u> Rinaldi Funeral Home		23b. ADDRESS <u>816 H St., N. E. Washington 2, D. C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13927

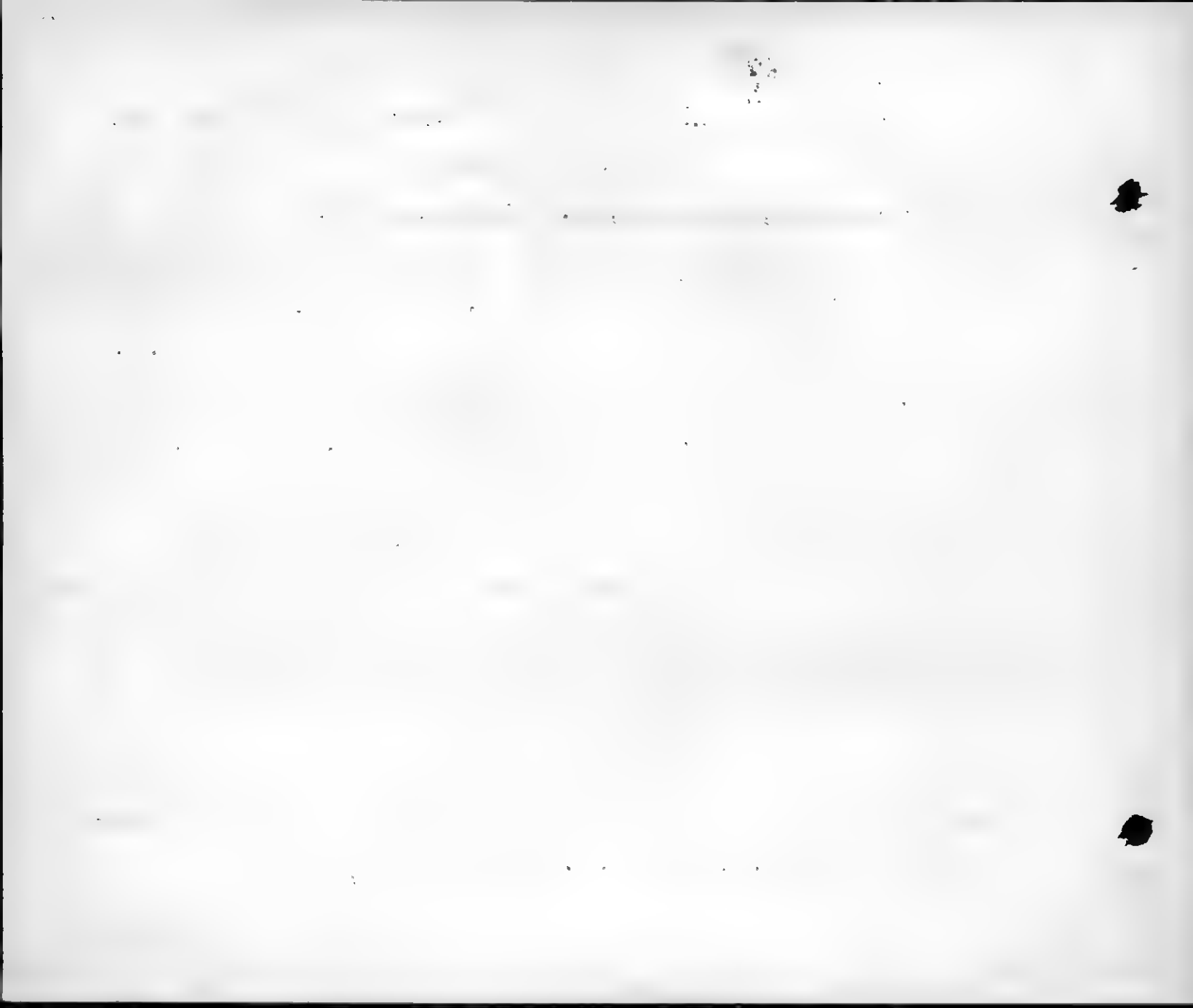
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 52 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 3216 Edgewood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charlotte		Middle (None)		Last Jackson	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1926	
				9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Housewife)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David L. Alpert				14. MOTHER'S MAIDEN NAME Sophia Stein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unascertainable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) P Respiratory failure 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive pulmonary infiltration and hemothorax days DUE TO (c) Malignant melanoma 22 month							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 19, 1959 , to December 10, 1959 that I last saw the deceased alive on December 10, 1959 , and that death occurred at 3:05 AM , from the causes and on the date stated above. Richard C. Mechanic ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12-10-59 ACTUAL SIGNATURE Richard C. Mechanic, M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 11, 1959		22c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY		22d. LOCATION (City, town, or county) (State) HYATTSVILLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS - 3501-14th St. N.W.				24a. RECEIVED BY REGISTRAR DATE DEC 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

VS TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 9/58



13953

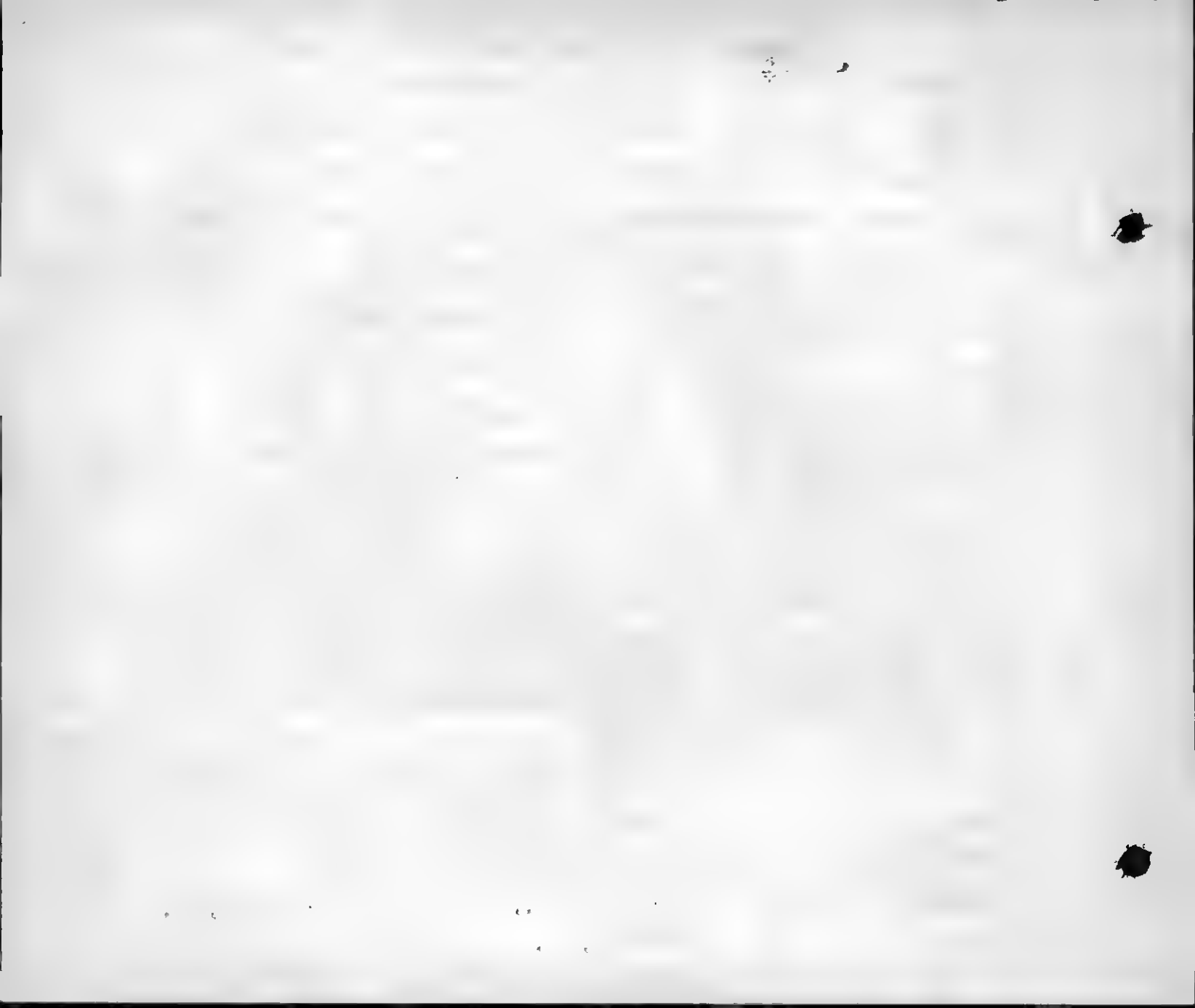
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13873

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>life</u>				d. STREET ADDRESS <u>8913 Brookville Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8913 Brookville Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Margaret Henderson James</u>				4. DATE OF DEATH <u>Dec 7 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-9-26</u>	
9. AGE (in years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>			
11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James A Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Harry James</u>				Address <u>Stuen 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left breast with</u> DUE TO <u>Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis</u> DUE TO (c) <u>Metastasis</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposition (specify) <u>Buried</u>		22b. DATE THEREOF <u>12/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial.</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert K. Swode</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No.

13929

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9301 Weaver St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>LEOKADIA</i> Middle <i>JASHEMSKI</i> Last <i>JASHEMSKI</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>23</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 1, 1888</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Rodziejowski</i>		14. MOTHER'S MAIDEN NAME <i>Marya</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Stanley A. Jaschewski</i>		Address <i>445 Rocking Mt. Rd., SSM, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Severe generalized arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic Heart Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>22 December 1959</i> to <i>23 December 1959</i> , that I last saw the deceased alive on <i>22 December, 1959</i> , and that death occurred at <i>6:40 A.M.</i> , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Russell B. Arnold</i>		ADDRESS (Street, city or town, state) <i>5801 Cokesville Road, Md.</i> DATE SIGNED <i>23 Dec '59</i>	
PHYSICIAN'S NAME (Type) <i>Russell B. Arnold M.D., Silver Spring, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<i>Burial</i>	<i>Dec 26, 1959</i>	<i>Greenwood Cemetery</i>	<i>York, Nebraska</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll St NW DC</i>	
24a. REC'D BY REGISTRAR <i>DEC 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13840

CERTIFICATE OF DEATH

13882

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
c. LENGTH OF STAY IN 1b <u>25 mins</u>			d. STREET ADDRESS <u>140 Bonifant St.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Kase</u> First <u>Washington</u> Middle <u>Jenkins</u> Last			4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-19</u>	9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Super. of Roads</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kosh Jenkins</u>			14. MOTHER'S MAIDEN NAME <u>Bertha Finchem</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes. W.W.II</u>			16. SOCIAL SECURITY NO <u>578 120491</u>		
17. INFORMANT <u>Hospital Records</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
			20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>Dec. 14</u> , 19 <u>59</u> , to <u>Dec. 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 14</u> , 19 <u>59</u> , and that death occurred at <u>11:15</u> P. M., from the causes and on the date stated above.					
1. ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D.			ADDRESS (Street, city or town, state) <u>9241 Col. Blvd</u> DATE SIGNED <u>12/14/59</u>		
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>			Silver Spring, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 18 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		22d. LOCATION (City, town, or county) (State) <u>Burtonsville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u> ADDRESS <u>Laytonville Md.</u>			24a. REC'D BY REGISTRAR <u>DEC 21 59</u> DATE		24b. REGISTRAR'S SIGNATURE

TO FURNISH TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be filed with the funeral director. The funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

Medical Examination - Dr. K. J. Jenkins, Jr., Certificate of Death, 12/14/59

and he is the only person signing the Certificate of Death, 12/14/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13883

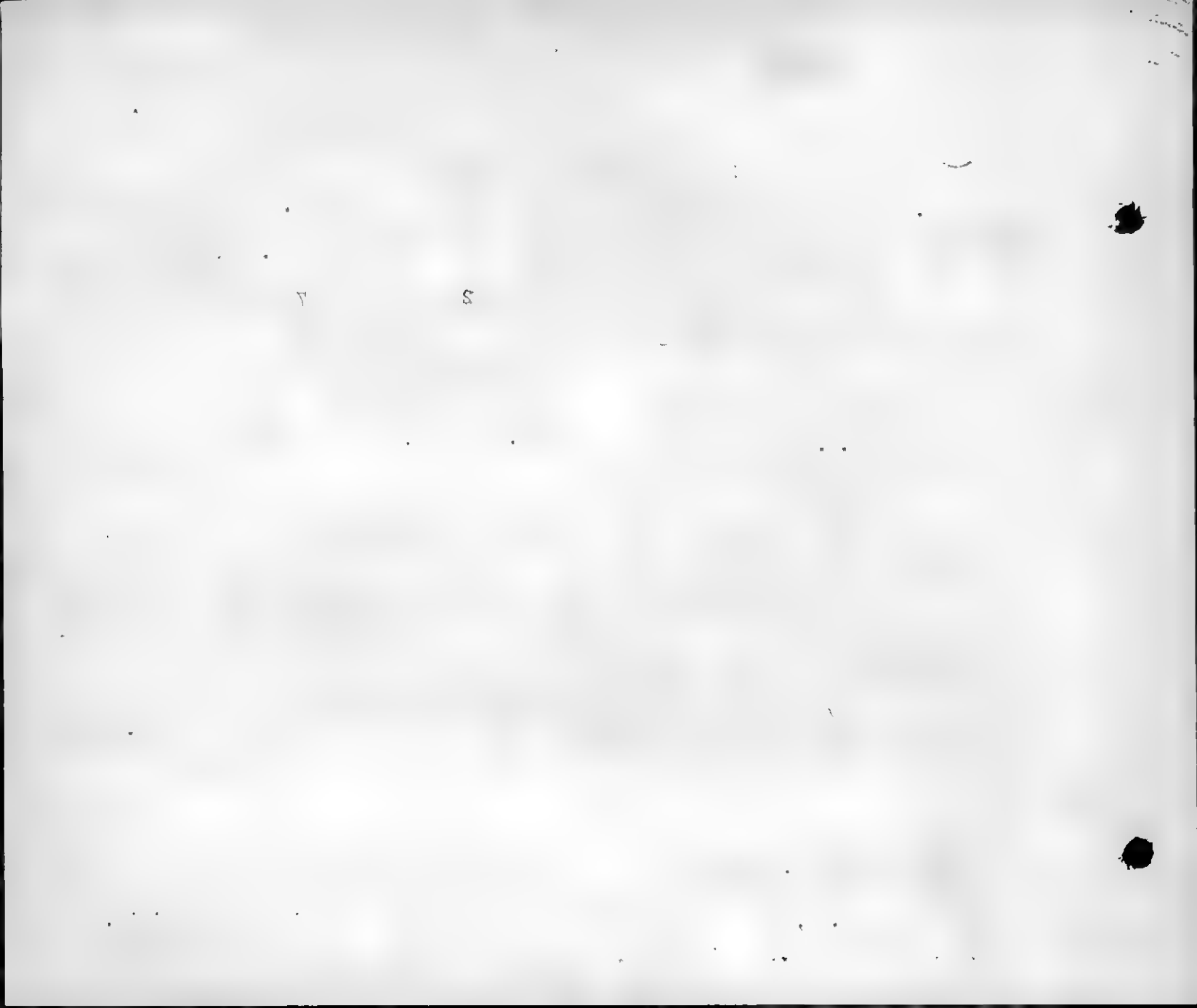
1384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
c. LENGTH OF STAY IN 1b 1 1/2 days				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. Sanatorium & Hospital			
d. STREET ADDRESS 7318 Carroll Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Adolph Jenkins First Middle Last				4. DATE OF DEATH Month Dec. Day 19, Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/12/08 1902		9. AGE (In years last birthday) 50 (57) rs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY Metro-Lithograph		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert M. Jenkins				14. MOTHER'S MAIDEN NAME Gloria Havener			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.II Unknown		17. INFORMANT Mrs. Jenkins.		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock DUE TO Hemorrhage & Laceration of left lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Shot Gun Wound INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted shot gun wound in left chest					
20c. TIME OF INJURY Month, Day, Year 6:40 o. m. 12/16/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Takoma Park Montg. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF Dec. 22, 1959		22c. NAME OF CEMETERY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Maryland.				24a. REC'D BY REGISTRAR DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13884

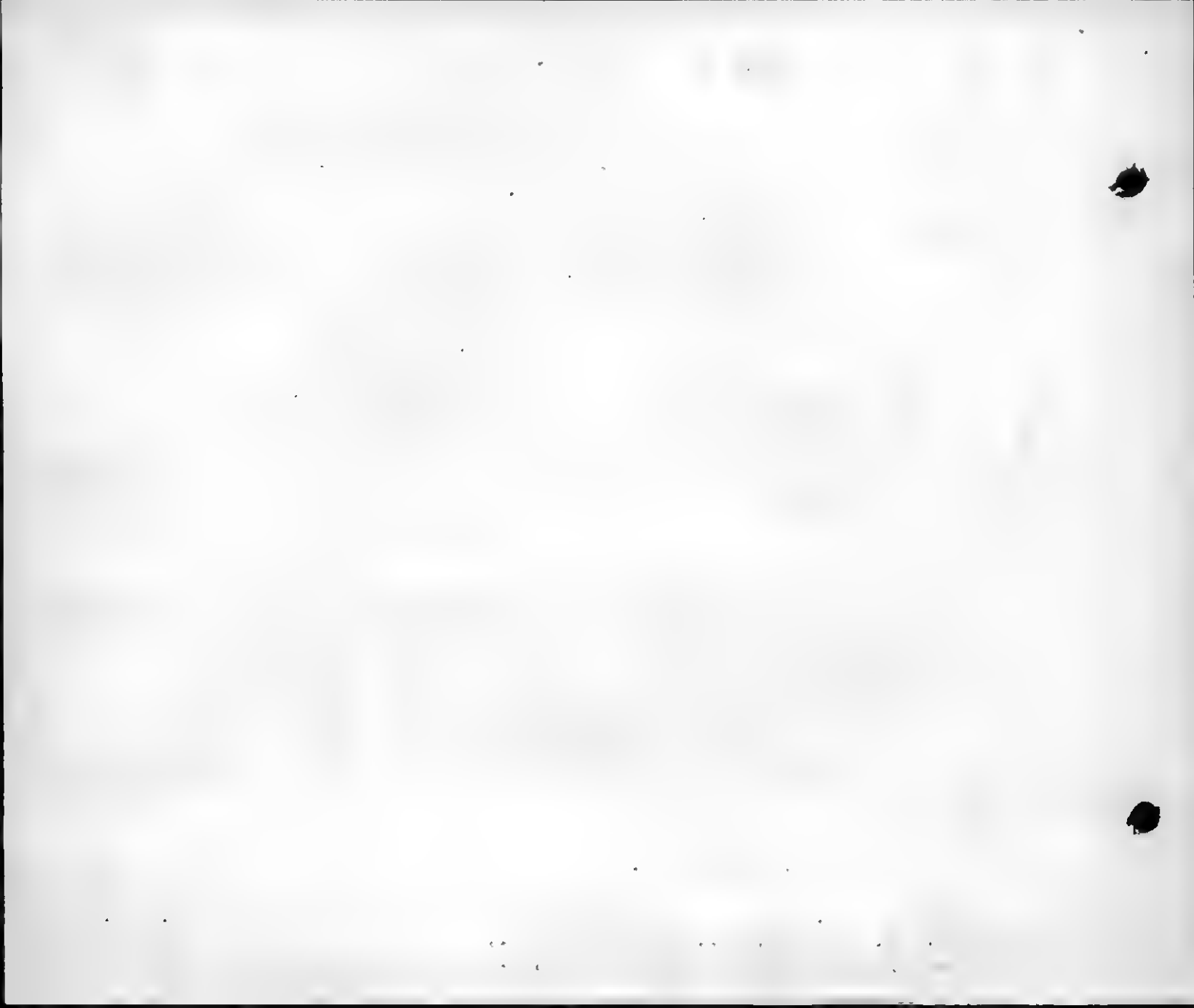
13931

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 25 HRS.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING, MARYLAND		d. STREET ADDRESS 721 MC NEIL LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JEFFERY BRIAN JENNINGS		First		Middle		Last		4. DATE OF DEATH Month DECEMBER Day 5 Year 1959		5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/4/59		9. AGE (In years last birthday) 7		IF UNDER 1 YEAR Months 11		IF UNDER 24 HRS Hours 11 Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES QUINTON JENNINGS		14. MOTHER'S MAIDEN NAME GRACE EVELYN SCHUSTER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. HOSPITAL RECORDS		17. ADDRESS OLNEY, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154.5 DUE TO Congenital anomalies of Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Day		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Congenital Defects		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 12/4 1959	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 12/5 1959		(County)		(State)		21. I certify that I attended the deceased from 12/4 1959 to 12/5 1959 , that I last saw the deceased alive on 12/5 1959 , and that death occurred at 10:58 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) SANDY SPRING, MARYLAND	
ACTUAL SIGNATURE C. H. LIGON, M. D.		M.D.		DATE SIGNED 12/5/59		PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
22d. LOCATION (City, town, or county) Prince George's Co., Md.		(State)		23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc., 843 Georgia Ave., Silver Spring, Md.		24a. REC'D BY REGISTRAR DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume		25. DATE DEC 8 '59		26. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13885

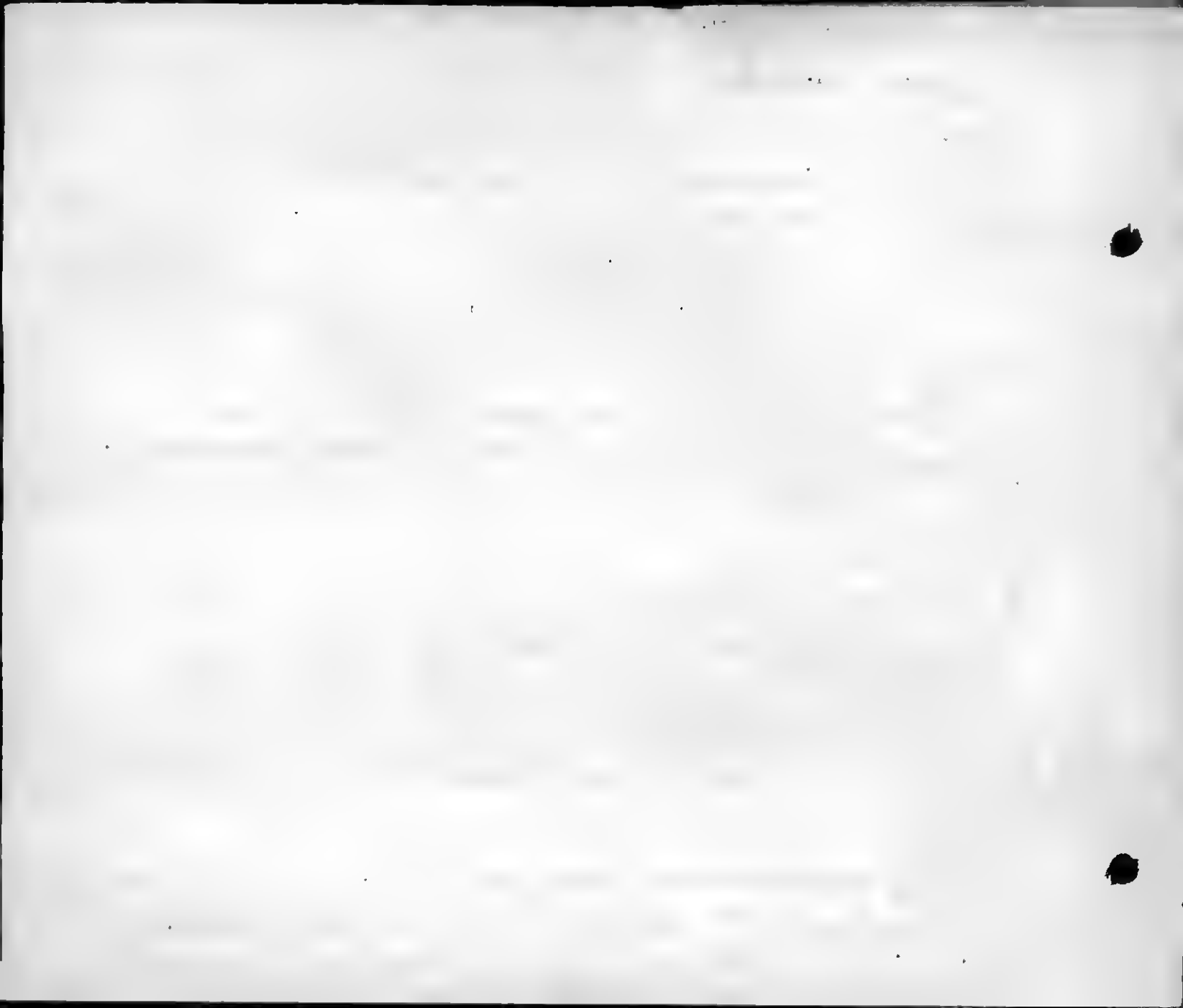
13932

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6821 Pineway	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium		d. STREET ADDRESS Hyattsville Md.	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle S. Last JOHNSON		4. DATE OF DEATH Month December Day 9 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 23, 1866
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Adam Sausen		14. MOTHER'S MAIDEN NAME Mary Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr Rayburn H Bamberg		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4 + 4X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) ESSENTIAL HYPERTENSION (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 10, 1958, to Dec. 9, 1959 , that I last saw the deceased alive on Dec. 9, 1959 , and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5206 Norway St. Hyattsville Md. DATE SIGNED Cherry Chong, M.D.			
ACTUAL SIGNATURE Cherry Chong, M.D.		PHYSICIAN'S NAME (Type) Cherry Chong, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 12, 1959	22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR DEC 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN TB <u>3 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stony Creek Rd</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>Stony Creek Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Other</u> Last <u>Johnson Jr.</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1959</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-15-1913</u>		9. AGE (In years last birthday) <u>46</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm C. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Knott</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>579-05-7549</u>		17. INFORMANT <u>Daisy Johnson (wife)</u> Address <u>Stony 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> DUE TO <u>973.1</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>found on floor of closed garage</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>3:15</u> p. m. <u>12-25</u> 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Rockville</u> (County) <u>Montg</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>12-25-59</u>					
22a. BURIAL, CREMATION, REMAINS (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. AT5ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 13887									
1. PLACE OF DEATH a. COUNTY MONTGOMERY					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) b. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG				
c. LENGTH OF STAY IN TB 2 HRS. 50 MIN.					d. STREET ADDRESS 11 RUSSELL AVENUE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY COUNTY GENERAL HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last LEE ALLNUTT JONES					4. DATE OF DEATH Month Day Year DECEMBER 6 19 59				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/18/92		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK - MONTGOMERY CO. ROAD DEPT.		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME GEORGE DARBY JONES					14. MOTHER'S MAIDEN NAME EVA WILES ALLNUTT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 2-5-45-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-00-01-02-03-04-05-06-07-08-09-10-1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13934

CERTIFICATE OF DEATH

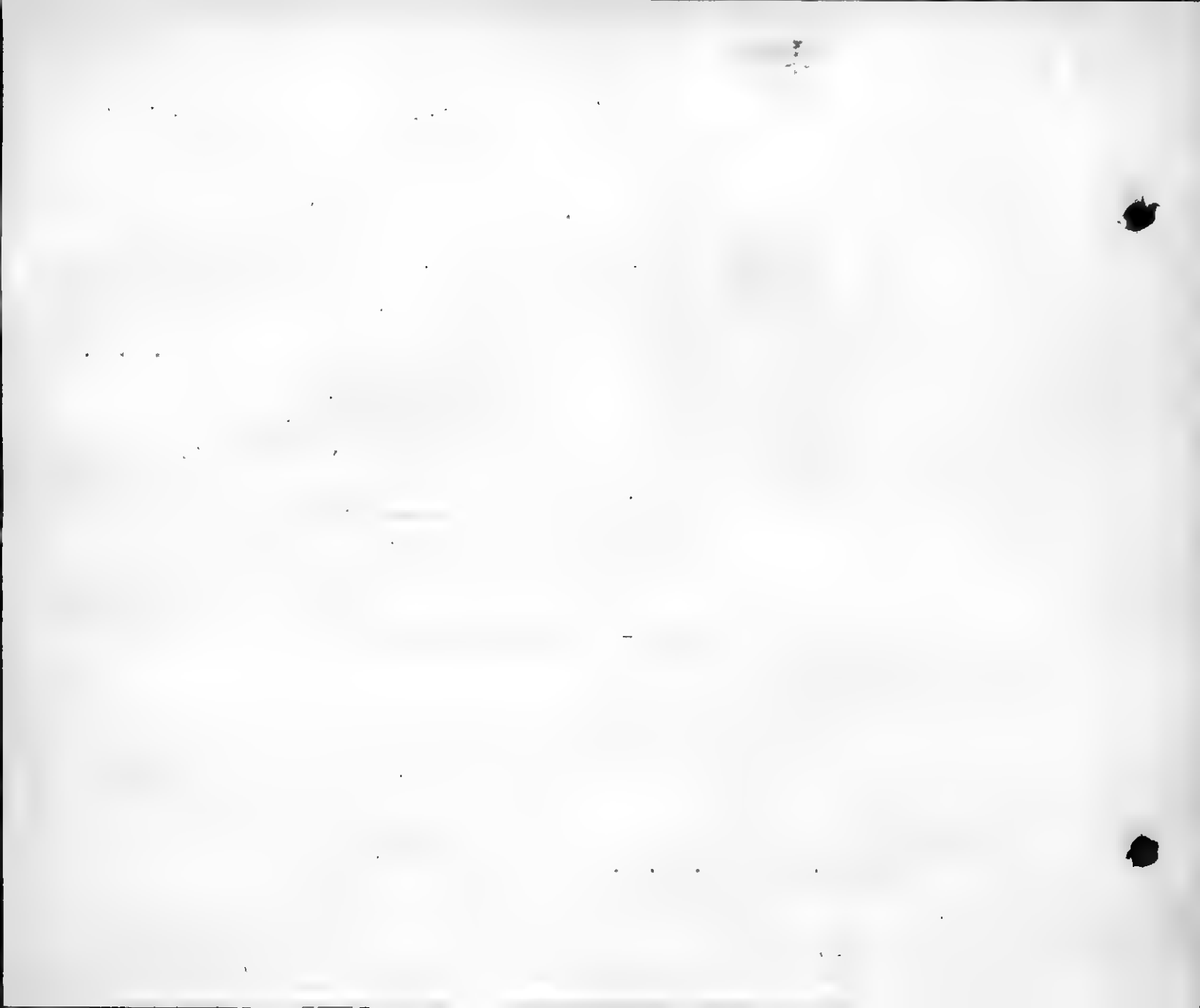
Reg. Dist. No.

13888

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. STREET ADDRESS 7608 Newmarket Drive			
3. NAME OF DECEASED (Type or print) First Ethlyn Middle Rita Last Kassel		4. DATE OF DEATH Month December Day 10 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1906
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 3 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS Months 3 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian		10b. KIND OF BUSINESS OR INDUSTRY Library	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Sol Cohn		14. MOTHER'S MAIDEN NAME Theresa Luster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hepatic coma DUE TO (b) metastatic cancer of breast with metastases to lungs, bone, and liver DUE TO (c) 3 1/2 years		INTERVAL BETWEEN ONSET AND DEATH hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gastrointestinal bleeding - ? due to liver disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 8, 1959 , to December 10, 1959 that I last saw the deceased alive on December 10, 1959 , and that death occurred at 7:15 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John L. Lewis Jr.		DATE SIGNED 12-10-59	
PHYSICIAN'S NAME (Type) JOHN L. LEWIS JR., M. D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 11, 1959	22c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL CEMETERY	22d. LOCATION (City, town, or county) (State) OXON HILL MD
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS		ADDRESS 3501-14th St. N.W.	
24a. REC'D BY REGISTRAR DEC 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13889

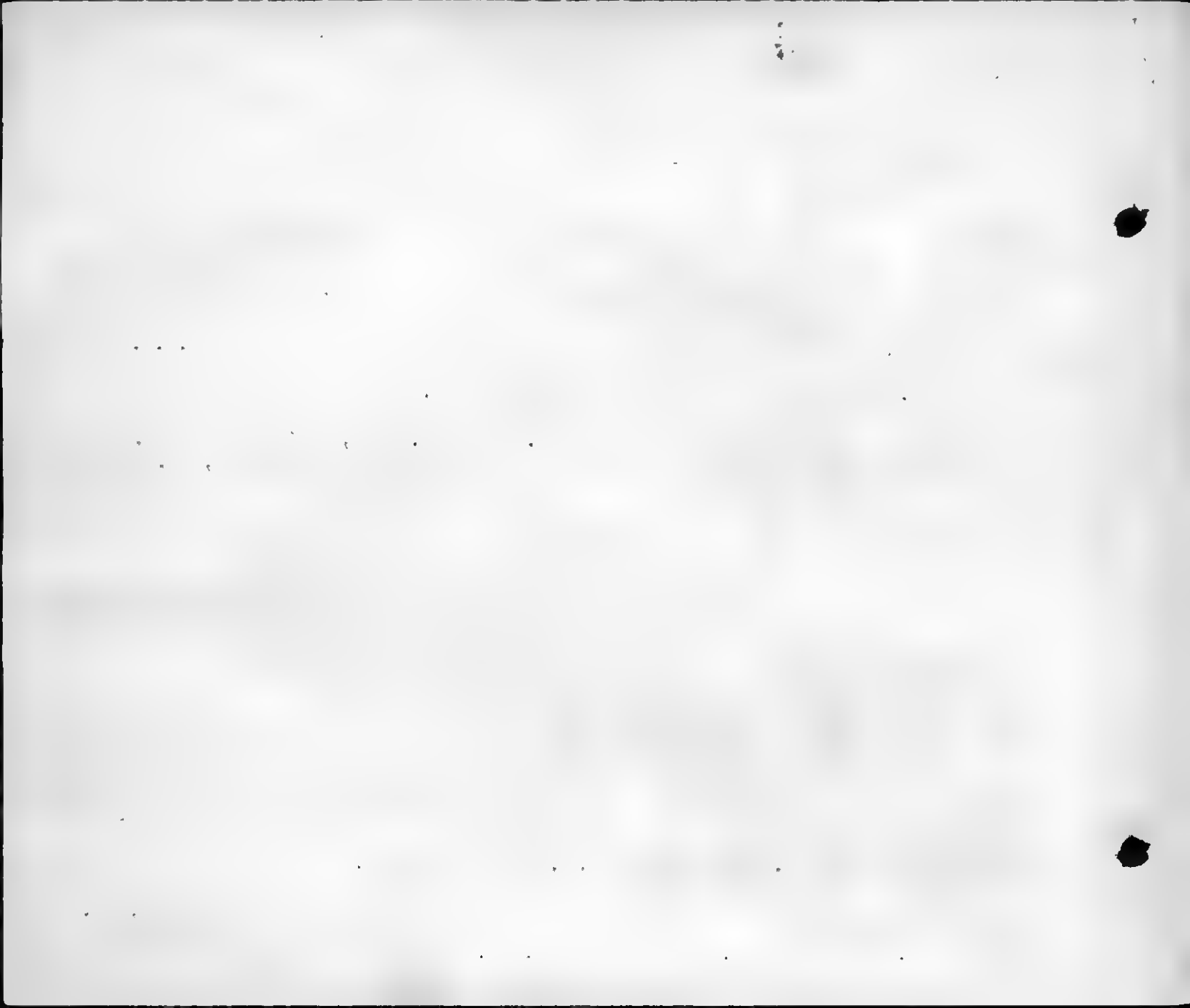
13935

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3700 Adams Drive		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KENSINGTON	
3. NAME OF DECEASED (Type or print) First THOMAS Middle WALTER Last KIRK		4. DATE OF DEATH Month December Day 18 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/81
9. AGE (In years lost birthday) yrs 78		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Excavating contractor		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry C. Kirk		14. MOTHER'S MAIDEN NAME Alice E. Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Bertha A. Kirk, 3112 McComas Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 491 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Cerebro-Vascular Accident			
19. INTERVAL BETWEEN ONSET AND DEATH Two Days Two Weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 59 , to Dec 18 , 19 59 , that I last saw the deceased alive on Dec 18 , 19 59 , and that death occurred at 3:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord St. Kensington, Maryland DATE SIGNED Dec 18, 1959			
ACTUAL SIGNATURE Robert T. Thibadeau M.D.		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		24c. REC'D BY REGISTRAR DATE DEC 22 '59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/21/59	
22c. NAME OF CEMETERY OR CREMATORY COLESVILLE METHODIST CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, INC.		24a. ADDRESS SILVER SPRING, MD.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13936

CERTIFICATE OF DEATH

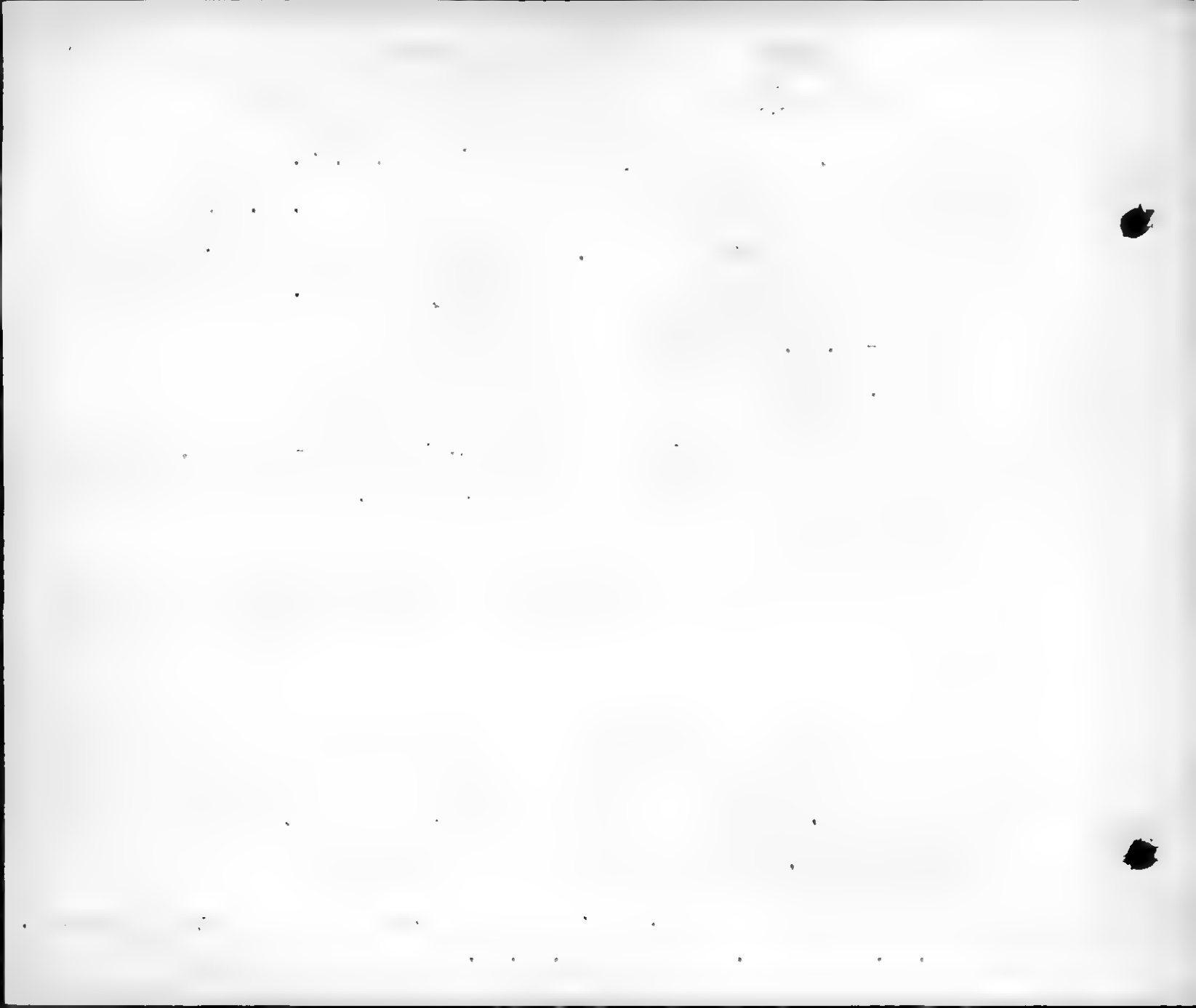
Reg. Dist. No.

13890

1. PLACE OF DEATH a. COUNTY Montgomery Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN 1b unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle B. Last Kistler		4. DATE OF DEATH Month December Day 2 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 81 ? yrs.		10. IF UNDER 1 YEAR Months ? Days ? Hours ? Min. ?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - U. S. Government		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry C. Bowen		14. MOTHER'S MAIDEN NAME Julia Childs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. ADDRESS James B. Straughn - Laurel, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Interoschrotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 years DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1 , 19 59 , to Dec. 3 , 19 59 , that I last saw the deceased alive on Nov. 29 , 19 59 , and that death occurred at 7:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thomascus, Md. DATE SIGNED ACTUAL SIGNATURE James P. Kerr M.D. FURNER'S NAME (Type) James P. Kerr			
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) cremation 12/2/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Et. Lincoln crematory		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		24a. REC'D BY REGISTRAR DEC 3 '59	
ADDRESS Washington, D. C.		24b. REGISTRAR'S SIGNATURE Carlton L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13842

CERTIFICATE OF DEATH

Reg. Dist. No. 13891

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Jan. & Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Carl</i> Middle <i>Oakford</i> Last <i>Klein</i>		4. DATE OF DEATH Month <i>12</i> Day <i>15</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-25-82</i>
9. AGE (In years last birthday) <i>77 yrs.</i>		10. IF UNDER 1 YEAR Months <i>77</i> Days <i>15</i> Hours <i>15</i> Min <i>15</i>	11. IF UNDER 24 HRS. Months <i>77</i> Days <i>15</i> Hours <i>15</i> Min <i>15</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Salesman - Cemetery</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>u.s.a</i>	
13. FATHER'S NAME <i>Charles Klein</i>		14. MOTHER'S MAIDEN NAME <i>Mary Alice Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Spanish-American</i>		16. SOCIAL SECURITY NO. <i>Son-in-law</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cardiovascular, renal failure</i> (c) <i>Diabetes mellitus</i> <i>Coronary Thrombosis Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Chronic</i> <i>Chronic</i> <i>Chronic</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic</i> <i>Chronic</i> <i>Chronic</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>December 15, 1959</i> to <i>December 15, 1959</i> , that I last saw the deceased alive on <i>December 15, 1959</i> , and that death occurred at <i>2:15 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1211/17</i> DATE SIGNED <i>12/15/59</i>	
ACTUAL SIGNATURE <i>Frank E. Williamson</i> M.D.		PHYSICIAN'S NAME (Type) <i>Frank E. Williamson</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-17-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Southland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home Wash. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 18 59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Smith</i>			

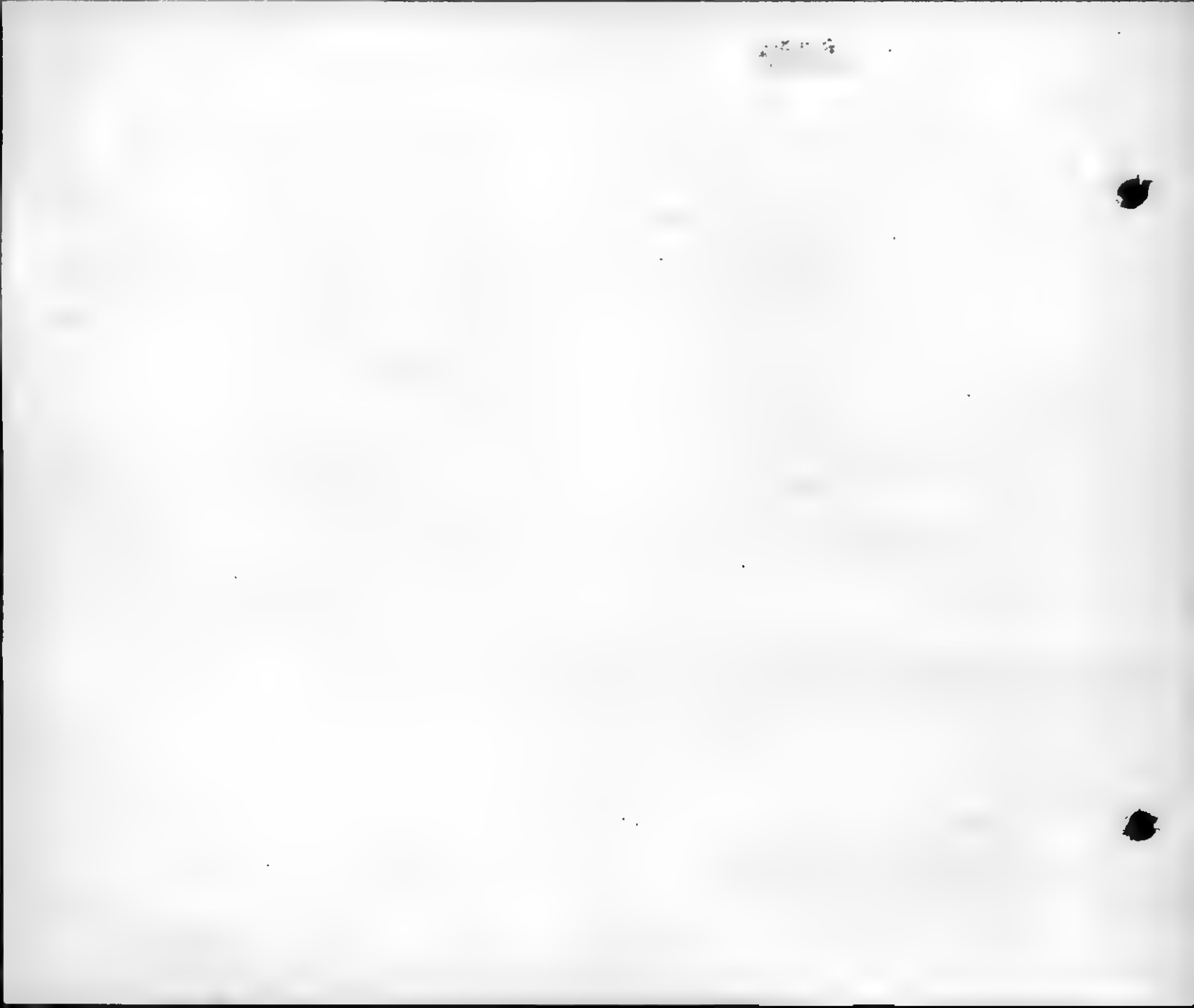
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13843

CERTIFICATE OF DEATH

Reg. Dist. No.

13892

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				d. STREET ADDRESS <u>7809 Greenwood Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Goldie</u> First <u>nmr</u> Middle <u>Knight</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-29-94</u>	
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>			
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Brown Hickson</u>				14. MOTHER'S MAIDEN NAME <u>unknown to girl's husband</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>pit chart &</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>23 years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Feb 3</u> , 19 <u>1956</u> to <u>4 Dec</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>4 Dec</u> , 19 <u>59</u> , and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1301 C-100ville Road, 12/4/59</u> DATE SIGNED <u>Russell B Arnold</u>							
ACTUAL SIGNATURE <u>Russell B Arnold</u> M.D.				PHYSICIAN'S NAME (Type) <u>Russell B Arnold M.D., 5110 Spring, Md.</u>			
22a. BURIAL, CREMATION, <u>Burial</u> (Specify)		22b. DATE THEREOF <u>Dec. 8, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges County</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Miller</u> DAY <u>254 Canal St. N. Wash. D.C.</u>				24. REC'D BY REGISTRAR <u>DEC 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Cuthbert S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Colonel
~~General~~ notified & approved the Arnold signing certificate

CERTIFICATE OF DEATH

Reg. Dist. No. 215

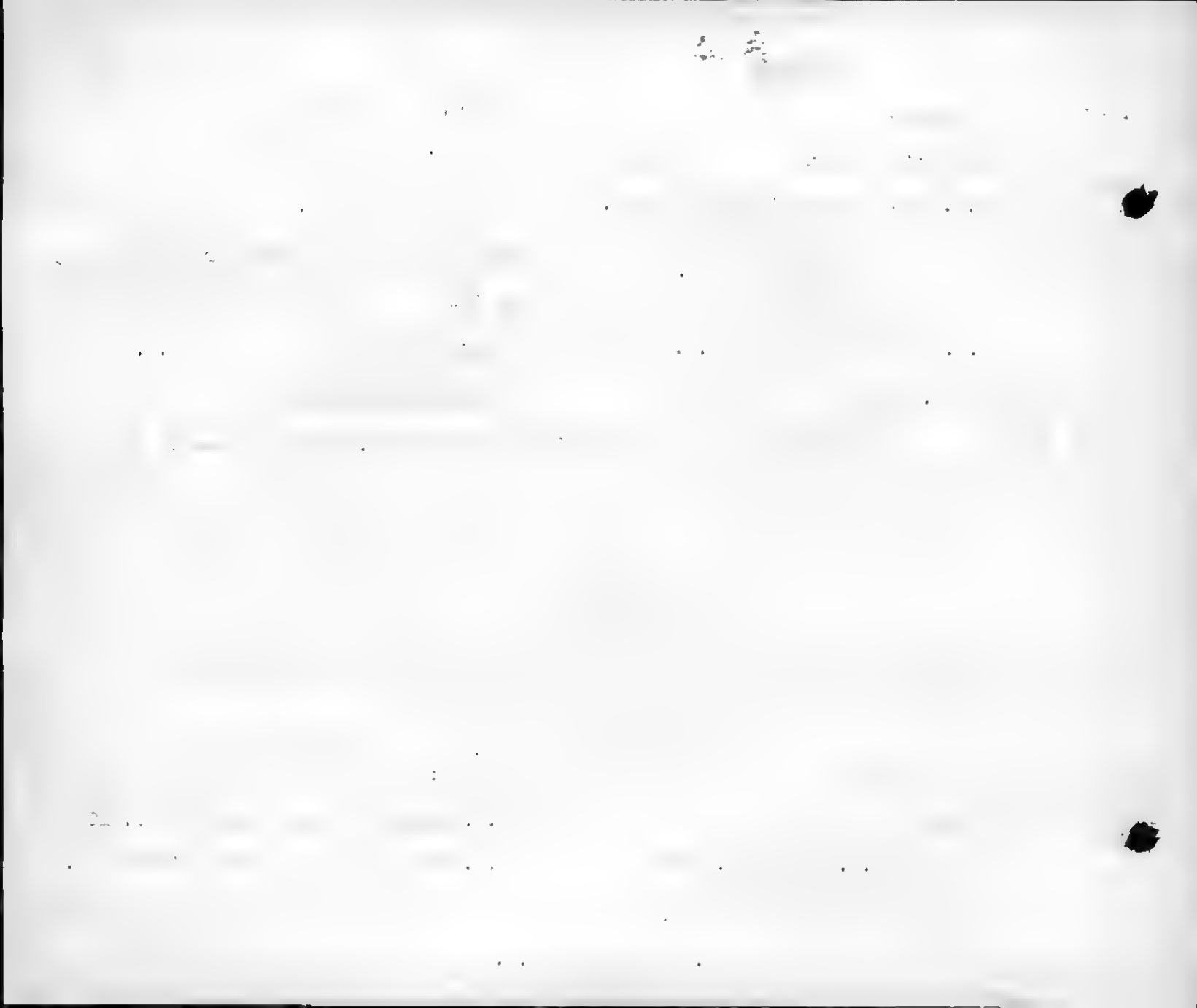
13937

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived If institution: Res dence before admiss on) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2500 Wisconsin Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lewis "L" KNIGHT		4. DATE OF DEATH Month Day Year December 1 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-11
9. AGE (In years last birthday) yrs. 48		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Low L. KNIGHT	
14. MOTHER'S MAIDEN NAME Isabella BRAZEAL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1930-1953	
16. SOCIAL SECURITY NO 527-46-3487		INFORMANT Address (Wife) Virginia B. Knight Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute cor pulmonale DUE TO (b) Pulmonary emphysema, endobronchial DUE TO (c) tuberculosis, bronchiogenic carcinoma INTERVAL BETWEEN ONSET AND DEATH 24 hours 6 years 6 months		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 62.1	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 November, 1959 , to 1 December, 1959 that I lost saw the deceased alive on 1 December, 1959 and that death occurred at 3:59A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 12-1-59			
ACTUAL SIGNATURE Vernon W. Houk		M.D. U.S. Naval Hospital, Bethesda Md. 12-1-59	
PHYSICIAN'S NAME (Type) V.N. HOUK LT MC USN		U.S. Naval Hospital, NMMC, Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-5-59	22c. NAME OF CEMETERY OR CREMATORY Oaklawn cemetery	22d. LOCATION (City, town, or county) (State) Hendersonville North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE De Vol 2224 Wisconsin Ave. Washington, D.C.		24a. REC'D BY REGISTRAR DATE DEC 4 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kiana

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 2

may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

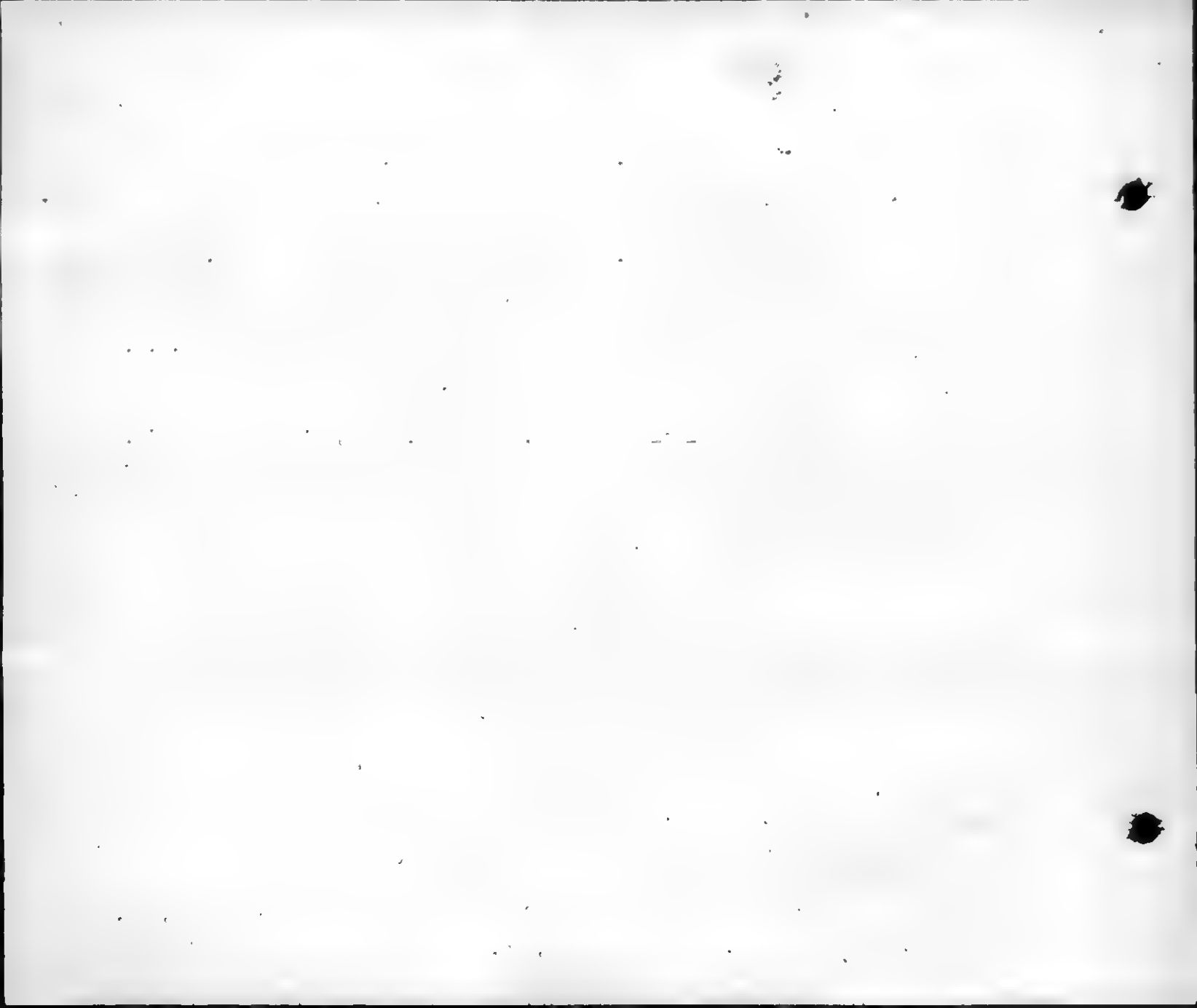
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4209 GLENROSE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMIL Middle W. Last KRYZ		4. DATE OF DEATH Month DEC. Day 8 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/12/92
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-28-7201	
17. INFORMANT Mrs. Bertha H. Kryz		Address 4209 Glenrose Rd. Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 294X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Polyarteria - Vera DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Occasional fibrillation INTERVAL BETWEEN ONSET AND DEATH 4-5 days 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/17/55 19 to 12/8/59 19, that I last saw the deceased alive on 12/8/59 19, and that death occurred at 12:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James A. O'Rourke M.D.			
PHYSICIAN'S NAME (Type) James A. O'Rourke MD 4501-Edmon Ave New Wash. DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/11/59	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. SILVER SPRING, MD. Raymond G. Ziska		24a. REC'D BY REGISTRAR DATE DEC 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

Page 4

TO HOSPITAL

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13844

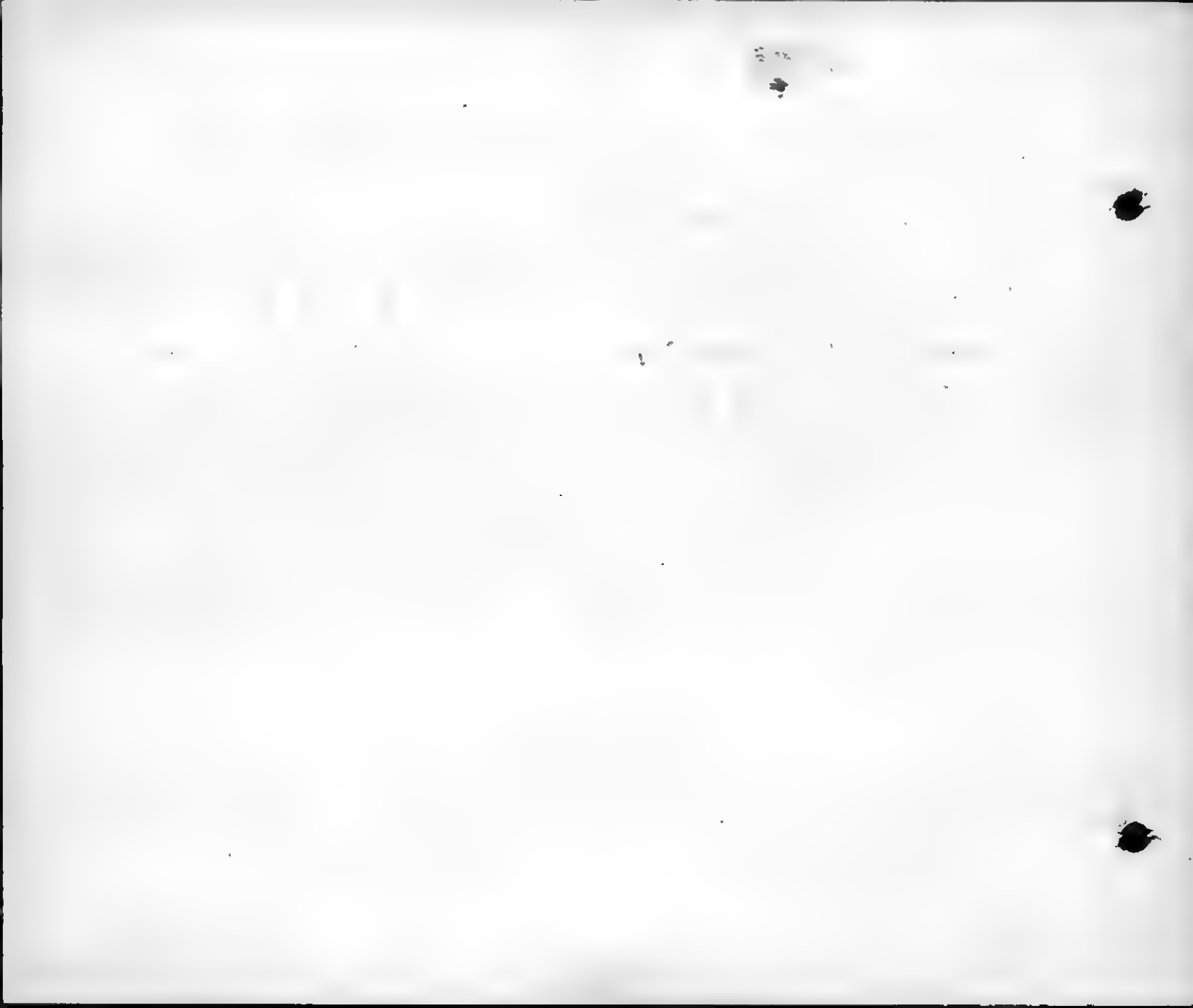
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>14 days</u>				d. STREET ADDRESS <u>16 Wessler Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>(W.M.)</u> Last <u>Kuhn</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-3-00</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>8</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>			
11. BIRTHPLACE (State or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Natasha ? Unknown to family</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4:20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>15 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 1956</u> to <u>Dec. 7, 1959</u> that I last saw the deceased alive on <u>December 6, 1959</u> and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Atkinson</u>				ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u> DATE SIGNED <u>12-7-59</u>			
PHYSICIAN'S NAME (Type) <u>Takoma Falls 12 Med.</u>							
22a. BURIAL, CREMATION, or other disposal (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>Dec 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fair Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James M. Atkinson</u> ADDRESS <u>254 Carroll St. N.W.</u>				24. REC'D BY REGISTRAR DATE <u>DEC 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13939

CERTIFICATE OF DEATH

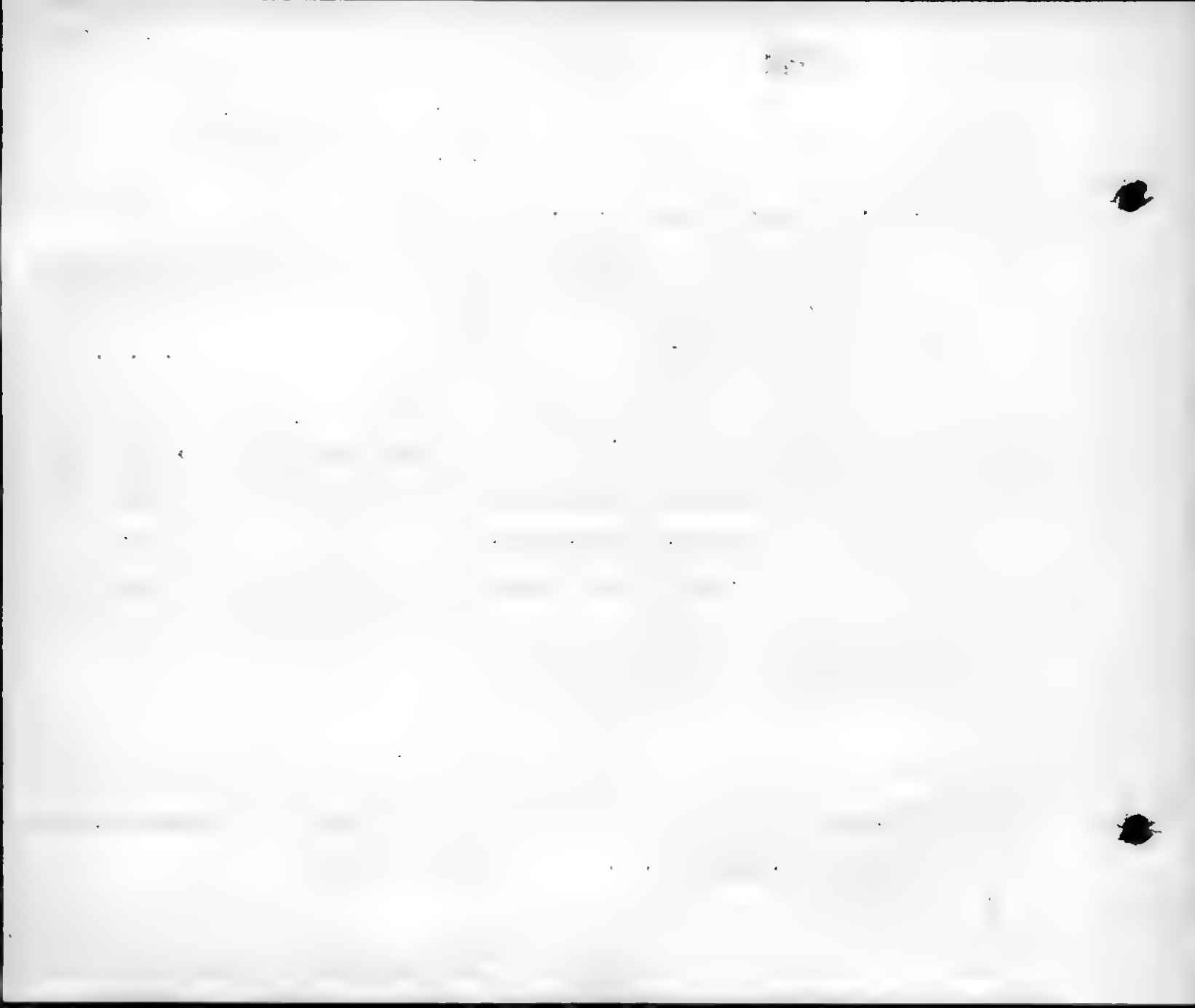
Reg. Dist. No.

13896

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia b. COUNTY Arlington ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 25X-2			
c. LENGTH OF STAY IN 1b 89 days				d. STREET ADDRESS 5912 North 9th Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Eve Middle (None) Last Laiken		4. DATE OF DEATH		Month December Day 28 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1904		9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.	IF UNDER 24 HRS Hours 55 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Feldman				14. MOTHER'S MAIDEN NAME Lena Goodman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 229-44-8744		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) hemopericardium & bleeding duodenal ulcer 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) cardiac decompensation DUE TO (c) chronic renal disease with uremia						INTERVAL BETWEEN ONSET AND DEATH days weeks months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from September 30 1959 , to December 28, 1959 , that I last saw the deceased alive on December 28, 1959 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Laurence E. Earley		M.D. The Clinical Center		ADDRESS (Street, city or town, state)		DATE SIGNED December 29, 1959	
PHYSICIAN'S NAME (Type) LAURENCE E. EARLEY, M. D.		National Institutes of Health		Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31-1959		22c. NAME OF CEMETERY OR CREMATORY Not New Park		22d. LOCATION (City, town, or county) (State) Falls Church Va	
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home		ADDRESS 4217 9th Ave NW		24a. REC'D BY REGISTRAR PC		24b. REGISTRAR'S SIGNATURE C. P. ...	
				DATE JAN 4 '60			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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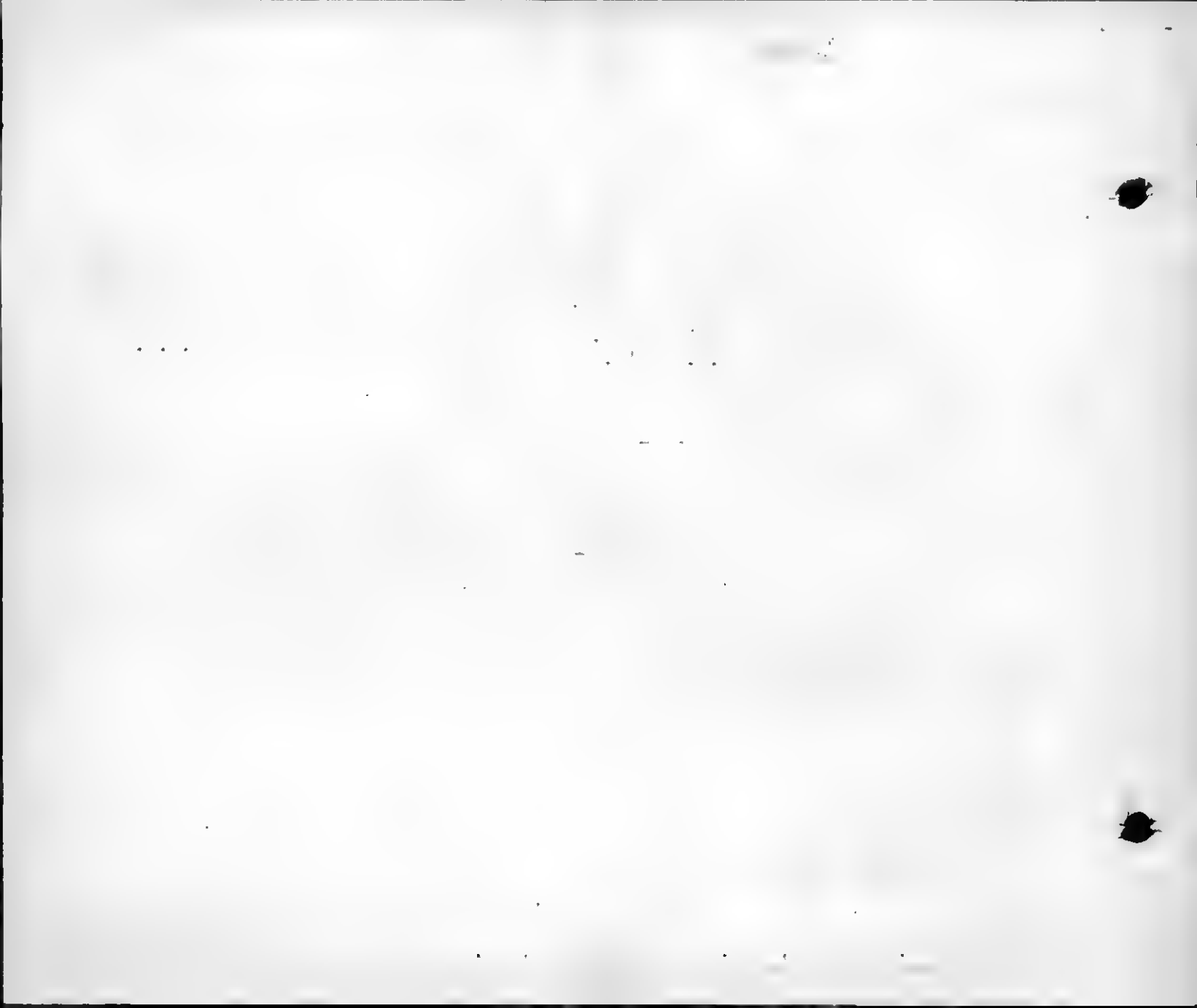
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VS A15 (4)
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **13845** **CERTIFICATE OF DEATH**

13897
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. and Hospital</u>				d. STREET ADDRESS <u>411 Silver Spring Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Joseph</u> Last <u>Lane</u>				4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12-5-'85</u>	
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Retired - govt employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown Lane</u>				14. MOTHER'S MAIDEN NAME <u>unknown Shea</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>271-05-9201</u>		INFORMANT <u>Hospital Records</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> DUE TO (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/16/56</u> , 19 <u> </u> , to <u>Dec 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 13</u> , 19 <u>59</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip C. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive Silver Spring, Md</u>					
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>		DATE SIGNED <u>12/13/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>DEC 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hous</u>	



1

13898

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13940

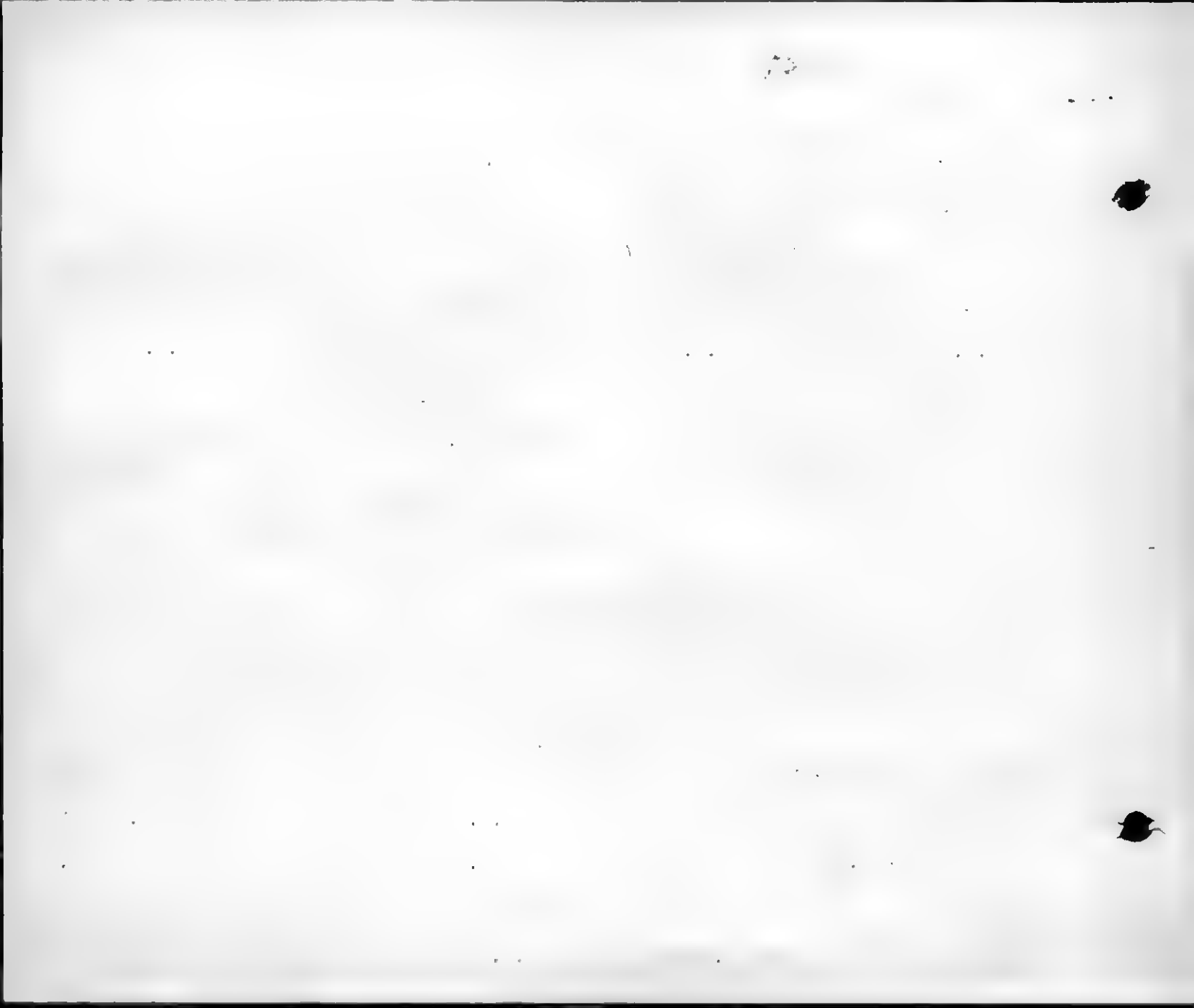
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 71 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida		b. COUNTY ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 2835 29th Avenue North				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First John		Middle (n)		Last LAW		4. DATE OF DEATH Month December	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-12-07		9. AGE (In years last birthday) 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John LAW	
14. MOTHER'S MAIDEN NAME Fanny BRANNAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. INFORMANT		Address (Wife) Mrs. Helen A Law Same as #2		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 16.1 Bronchogenic Carcinoma of Lung DUE TO C multiple metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 20 October 1959 to 30 December 1959 , that I last saw the deceased alive on 30 December 1959 and that death occurred at 6:50 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.	
ACTUAL SIGNATURE John Walter Lewis		DATE SIGNED 12-30-59		PHYSICIAN'S NAME (Type) J.M. LEWIS LT MC USNR		U.S. Naval Hospital, NNMC, Bethesda Md.		22a. REC'D BY REGISTRAR DATE JAN 5 '60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-14-60		22c. NAME OF CEMETERY OR CREMATORY Peacedale Cemetery		22d. LOCATION (City town, or county) Highland Falls, New York		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi 816 "H" Street N.E. Washington, D.C.		ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE JAN 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13890

Reg. Dist. No.

13846

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>District of Columbia</u> COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>321 W. ST. N.E. Wash D.C.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard William Lawhorn</u>				4. DATE OF DEATH Month Day Year <u>12 7 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-1-84</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Amherst Co. Leesburg Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Fitz Patrick Lawhorn</u>				14. MOTHER'S MAIDEN NAME <u>I da Kate Grant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578096398</u>		17. INFORMANT Address <u>Mrs Catherine Lawhorn 8423 12th Ave Langley Park Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO <u>juv</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.V.A. about 3 yrs ago</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>12-7-59</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 10, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. HILL BURIAL PARK</u>		22d. LOCATION (City, town, or county) (State) <u>LYNCHBURG, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Peter Walters</u> ADDRESS <u>254 Canoll St. NW</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13900
Item 20 Film 253 12-23-59 ams										13941
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5006 Hampden Lane					d. STREET ADDRESS 5006 Hampden Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle M Last Lehman			4. DATE OF DEATH Month Dec. Day 7 Year 19 59							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1868		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months 11 Days 6		IF UNDER 24 HRS Hours Min 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington D. C.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Michael O'Connor					14. MOTHER'S MAIDEN NAME Ellen Myers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. None		INFORMANT Address Marie L. Kealy-daughter-same as 2d					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Arteriosclerotic Pneumonia 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Direct Heart (c) Generalized Arteriosclerosis									INTERVAL BETWEEN ONSET AND DEATH 2 days 7 Months YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Lamin over to pick up a string & fell - taken to Suburban Hospital & surgery performed 10 pm that nite							
20c. TIME OF INJURY Month, Day, Year Hour 6 p. m. May 29 19 59			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Her Home		20f. (City or town) (County) (State) Bethesda Mont. Maryland			
21. I certify that I attended the deceased from May 56 , 19 56 , to Dec 7 , 19 59 , that I last saw the deceased alive on Dec 6 , 19 59 , and that death occurred at PA M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8016 Georgetown Rd. Bethesda Md DATE SIGNED 12/8/59										
ACTUAL SIGNATURE Leo I. Donovan			M.D. 8016 Georgetown Rd. Bethesda Md							
PHYSICIAN'S NAME (Type) Leo I. Donovan, M.D.			8016 Old Georgetown Rd. Bethesda Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12/10/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey					ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE DEC 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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146

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

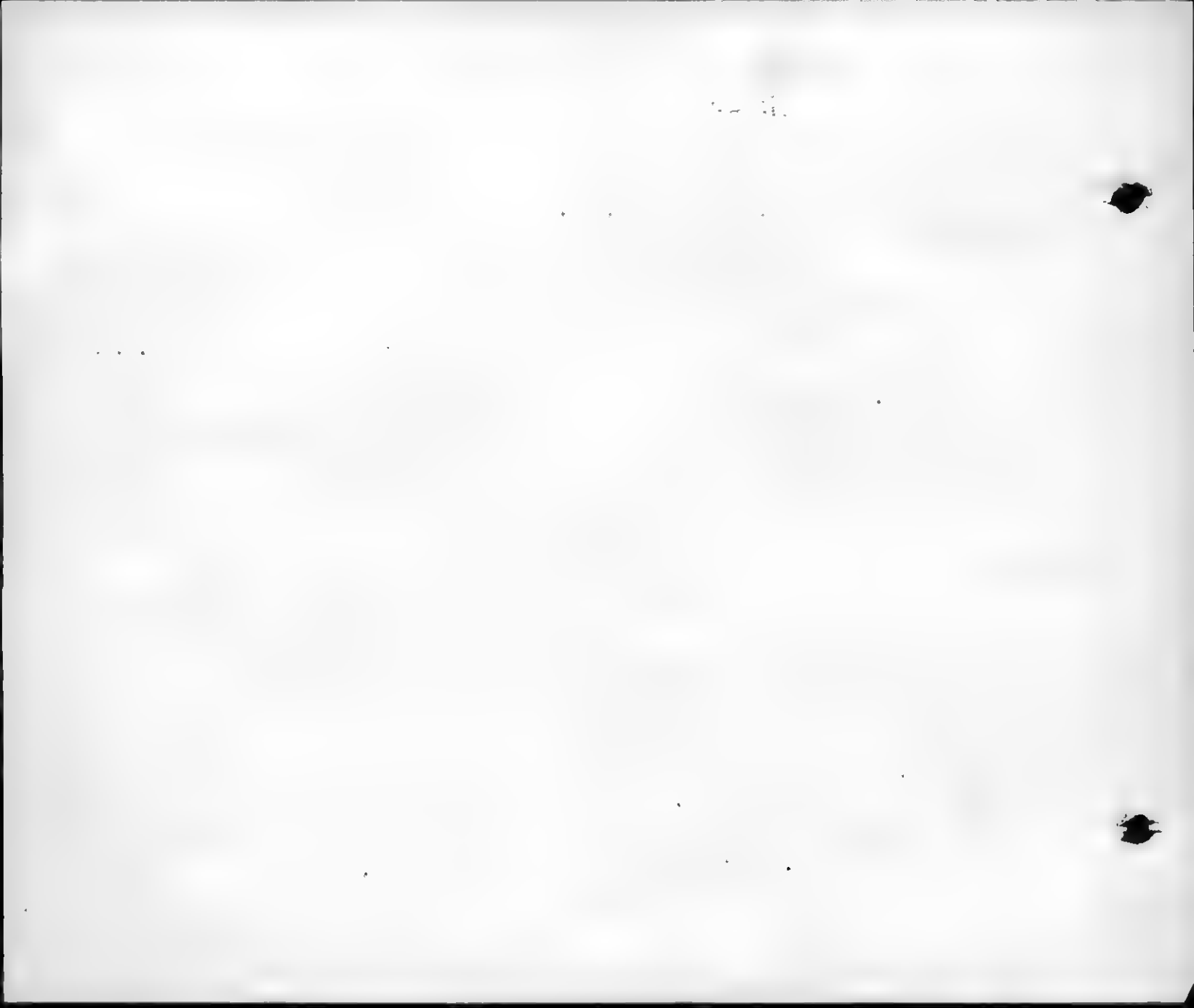
Reg. Dist. No.

13942

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>67x-2</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City (Brooklyn)</u>			
c. LENGTH OF STAY IN lb <u>21 days</u>				d. STREET ADDRESS <u>903 Avenue S</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Allen</u> Last <u>Lorowitz</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 May 1956</u>	
9. AGE (In years last birthday) <u>3</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Herman Z. Lorowitz</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Kramer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>The Medical Record</u>				Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive gastro - intestinal hemorrhage</u>							
DUE TO (b) <u>Acute lymphocytic leukemia</u>							
DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 17, 1959</u> to <u>December 8, 1959</u> that I last saw the deceased alive on <u>December 8, 1959</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles E. Mengel M.D.</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u>			
FITSZBERG'S NAME (Type) <u>Charles E. Mengel M.D.</u>				DATE SIGNED <u>12/8/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-9-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Goldberg Funeral Home</u>	
22d. LOCATION (City, town, or county) <u>Springfield</u>				(State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				ADDRESS <u>West</u>		24a. REC'D BY REGISTRAR <u>DEC 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



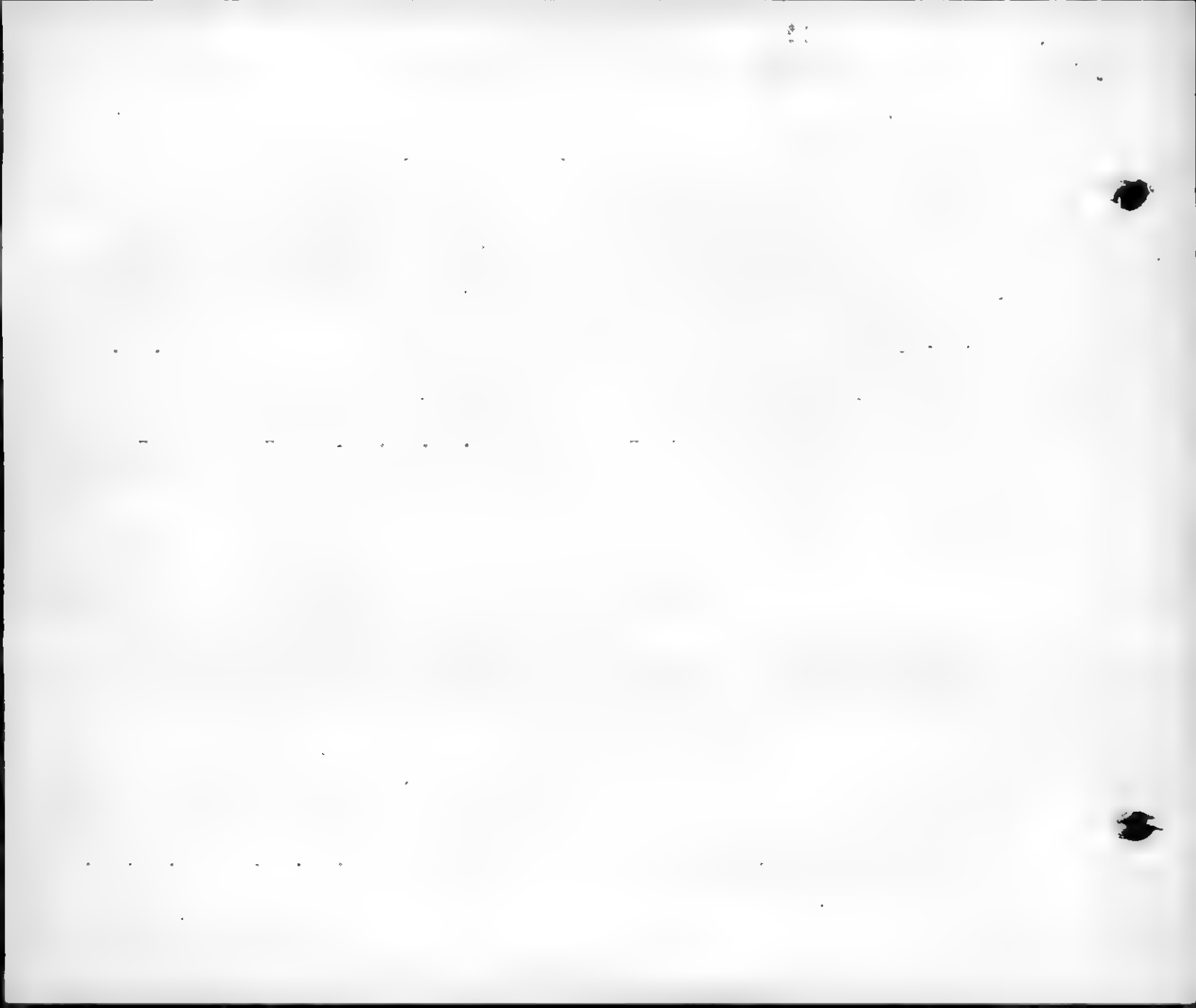
CERTIFICATE OF DEATH

Reg. Dist. No.

13902

13943

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb 1 1/2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9533 East Bexhill Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle P Last LOWER		4. DATE OF DEATH Month December Day 10 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/1871
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Potter		14. MOTHER'S MAIDEN NAME Lavinia Hartley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 511-12-9186-A	
17. INFORMANT Mrs. L. B. Crabbs-daughter-same 2d		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 10 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from Nov. 1 , 19 59 , to Dec. 10 , 19 59 that I last saw the deceased alive on Dec. 5 , 19 59 , and that death occurred at 2 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifton R. Gruver		ADDRESS (Street, city or town, state) 4325 49th St. N. W. Wash. D. C.	
PHYSICIAN'S NAME (Type) Clifton R. Gruver		DATE SIGNED 12/10/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 12/10/59	
22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		22d. LOCATION (City, town, or county) (State) Washington, Kansas	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DEC 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6254 12-30-59 et

CERTIFICATE OF DEATH

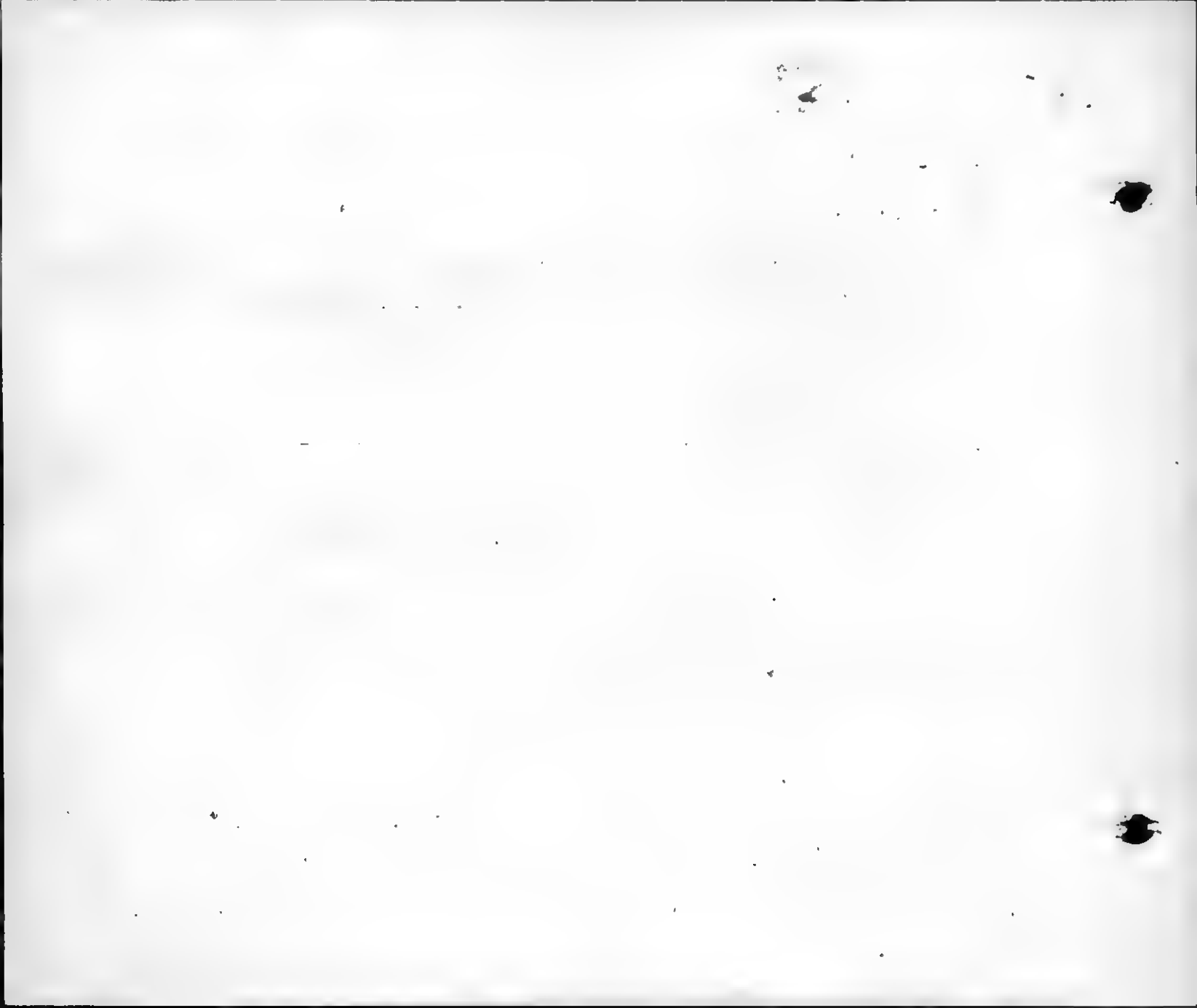
Reg. Dist. No.

13944

13903

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carrol Hall c. LENGTH OF STAY IN 1b Carrol Hall d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Kensington, Maryland		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4903 Montgomery Lane d. STREET ADDRESS Bethesda, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLE G. Middle Lucas Last 4. DATE OF DEATH Month 12 Day 18 Year 1959		5. SEX 7 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 5, 1895 9. AGE (In years last birthday) 64 yrs. 10. IF UNDER 1 YEAR Months 3 Days 13 Hours 13 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Kendrick		14. MOTHER'S MAIDEN NAME Sacks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Yes-Unknown	
17. INFORMANT William Lucas-son-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio sclerosis generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-2, 1959 to 12-18, 1959 , that I last saw the deceased alive on 12-18, 1959 , and that death occurred at 8:35 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Alfred S. Norton M.D.		ADDRESS (Street, city or town, state) Bethesda Md DATE SIGNED 12-18-59	
PHYSICIAN'S NAME (Type) Alfred S. Norton		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 12/20/59	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town or county) (State) Jacksonville, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DEC 24 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13945

CERTIFICATE OF DEATH

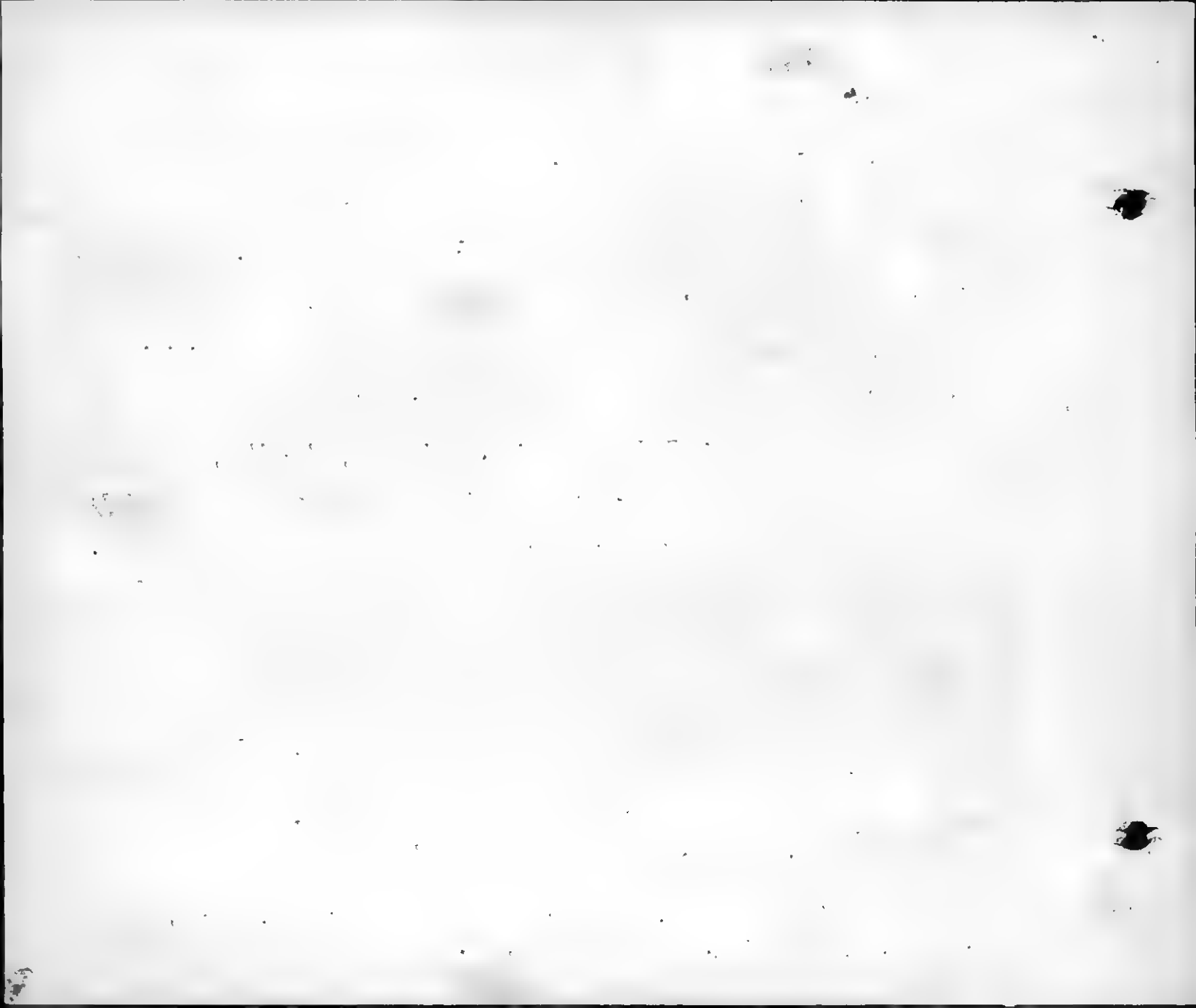
Reg. Dist. No.

1 PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. LENGTH OF STAY IN 1b 35 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4321 Leland Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle AGNES Last MAGRUDER		4. DATE OF DEATH Month DEC. Day 17 Year 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/82
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress (retired)		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES LEAMAN		14. MOTHER'S MAIDEN NAME EVELYN M. GLOYD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-50-2558	
17. INFORMANT Mr. John H. Magruder, Sr.		Address 1024 Paul Drive, Rockville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr. 5 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 1958 to DEC. 17, 1959 , that I last saw the deceased alive on DEC. 17, 1959 , and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8218 Wisconsin Ave. Bethesda, Maryland DATE SIGNED 12/17/59			
ACTUAL SIGNATURE Leo M. Curtis		M.D. 8218 Wisconsin Ave. Bethesda, Maryland	
PHYSICIAN'S NAME (Type) LEO M. CURTIS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/21/59	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE DEC 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

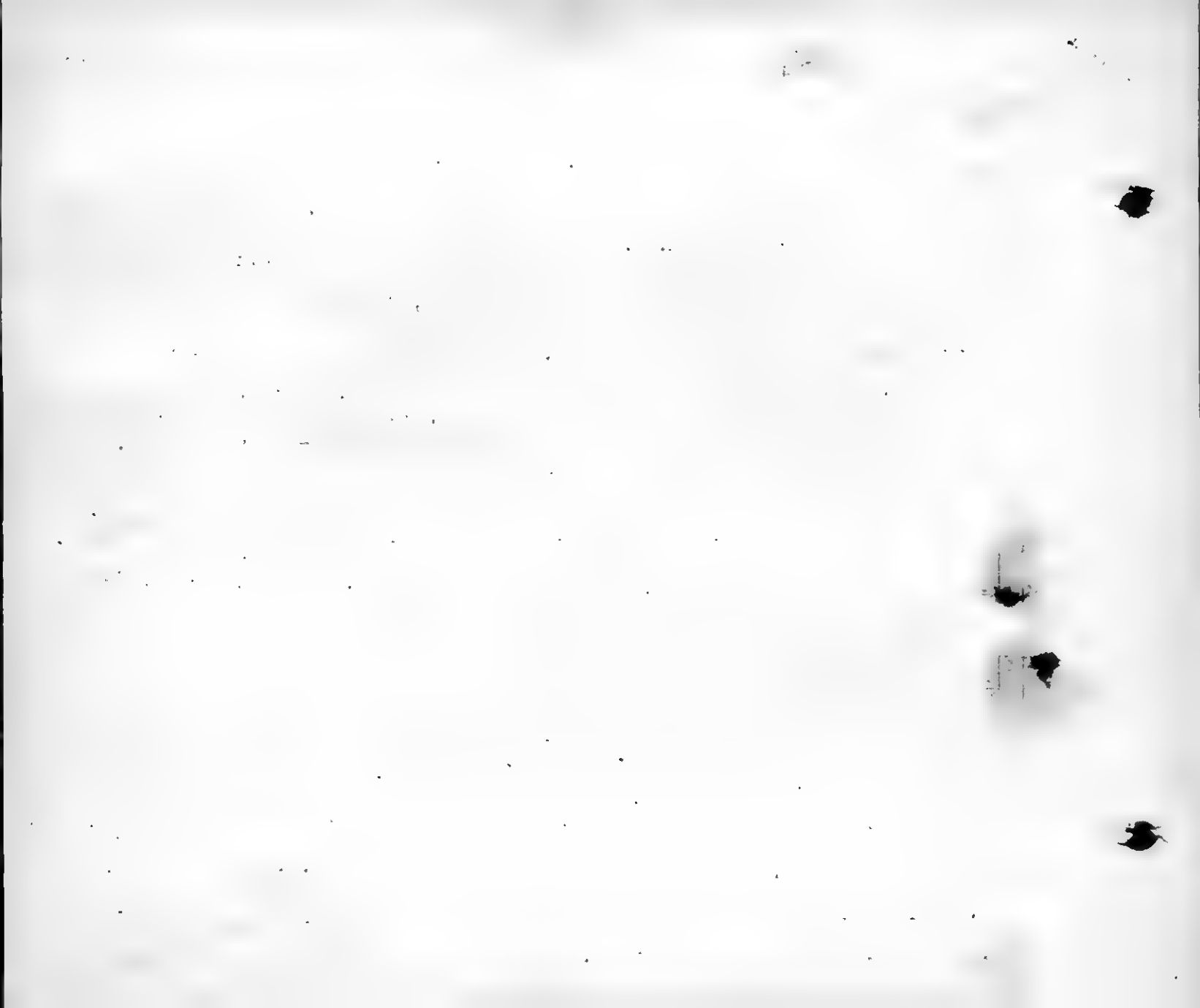
Reg. Dist. No.

13905

13946

1. PLACE OF DEATH a. COUNTY M ontgomery M ARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 14 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Su burban Hospital				d. STREET ADDRESS 5311 Roosevelt St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pau la Middle E. E. Last Mahler				4. DATE OF DEATH Month December Day 21 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1892		9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months 9 Days 17	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY private pract.		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Antone Treidl				14. MOTHER'S MAIDEN NAME Louise Kastner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Montreal, Canada Address Sister Louise Treidl-Kahn-8514 Cote St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Heart loss, hypotension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) ruptured abdominal aortic aneurysm DUE TO 1 day (c) 14 hrs							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Jan 19 54 to 12-21-59 , that I last saw the deceased alive on 12-21-59 and that death occurred at 12-21-59 from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE John O. Robben		ADDRESS (Street, city or town, state) 7930 Georgia Ave Silver Spring Md					
PHYSICIAN'S NAME (Type) John O. Robben		7930 Georgia Ave. Silver Spring Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/23/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

13906

Reg. Dist. No.

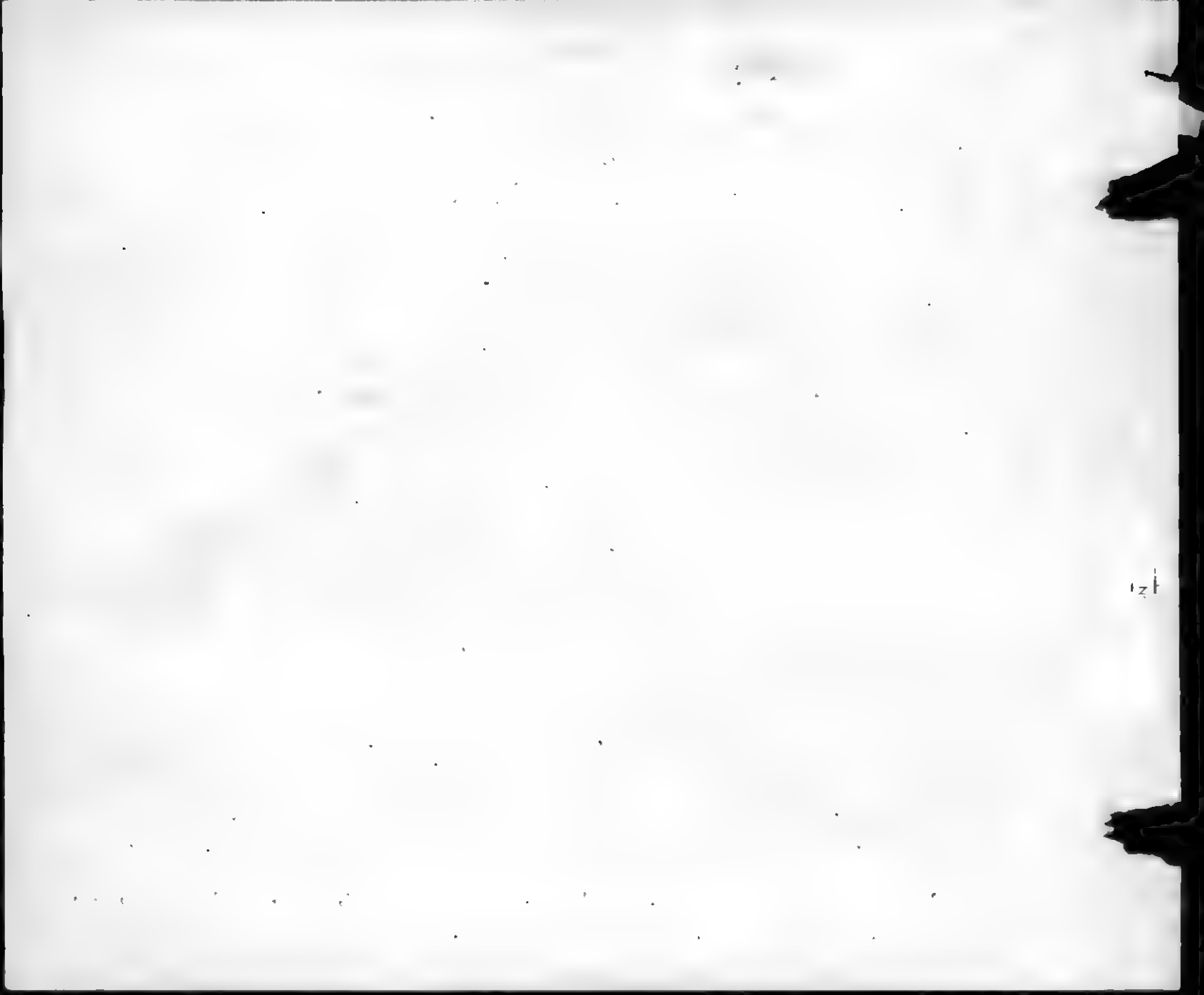
13847

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. STREET ADDRESS <u>9805 Cokesville Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Samuel Childs McConey</u>		4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done, name of firm, or life, even if retired) <u>Construction Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George B. McConey</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Childs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last (b) <u>Myocardial infarction</u> DUE TO <u>Myocardial infarction</u> (c) <u>Myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 month</u> <u>1 month</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 1951, to <u>Dec. 23</u> , 1959, that I last saw the deceased alive on <u>Dec. 22</u> , 1959, and that death occurred at <u>4:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merrill M. Cross</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8248 GEORGIA AVE. 12/23/59</u>	
PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS</u>		<u>SILVER SPRING, MARYLAND.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Episcopal Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Funn</u>	

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITAL: This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13947

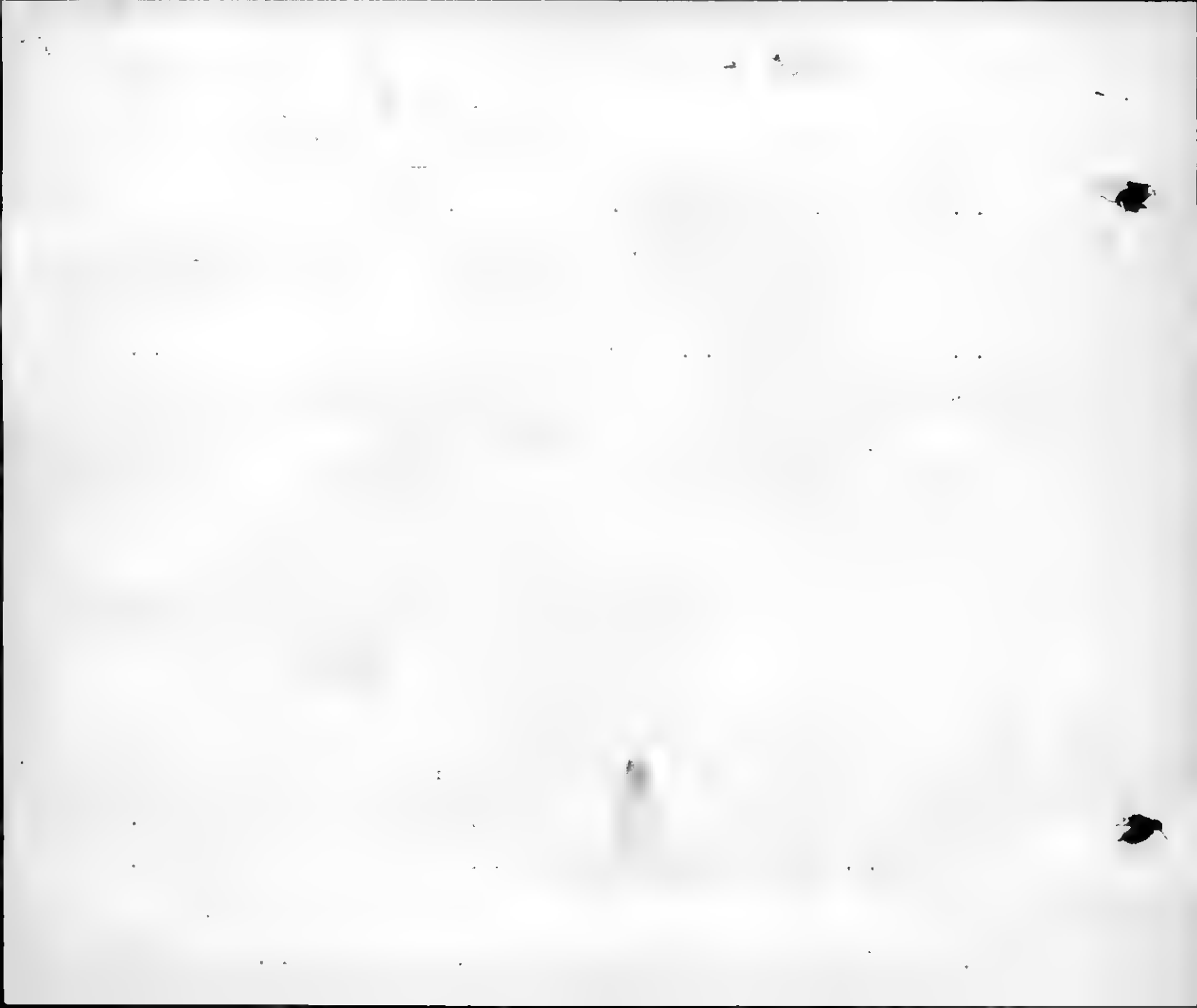
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 109 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY Evansville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Evansville d. STREET ADDRESS 511 E. Franklin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Lawrence MC DANIEL		4. DATE OF DEATH Month Day Year December 21 1959	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-27
9. AGE (In years lost birthday) yrs 32	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps	10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) Illinois
12 CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Isaac MC DANIEL	
14. MOTHER'S MAIDEN NAME Evelyn FITZGERALD		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II	
16. SOCIAL SECURITY NO Informant		Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 36 hours 2 1/2 years			INTERVAL BETWEEN ONSET AND DEATH 36 hours 2 1/2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I attended the deceased from 3 September, 1959 to 21 December, 1959 , that I last saw the deceased alive on 21 December, 1959 , and that death occurred at 4:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 12-21-59			
ACTUAL SIGNATURE James M. Young		M.D. U.S. Naval Hospital, Bethesda Md. 12-21-59	
PHYSICIAN'S NAME (Type) J.M. Young LT MC USN		U.S. Naval Hospital, Bethesda Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-24-59	22c. NAME OF CEMETERY OR CREMATORY Evansville Ind.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Funeral Home		24a. REC'D BY REGISTRAR Washington D.C.	24b. REGISTRAR'S SIGNATURE Arthur S. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 13908

13948

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ann Middle Elizabet Last McHugh		4. DATE OF DEATH Month 12 Day 31 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/7/17
9. AGE (In years last birthday) 42 yrs.		10. UNDER 1 YEAR Months 12 Days 31 Hours 00 Min 00	11. UNDER 24 HRS Months 00 Days 00 Hours 00 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY US Gov.	
11. BIRTHPLACE (State or foreign country) FLORIDA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS A. SMITH		14. MOTHER'S MAIDEN NAME ESTHER HINSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-09-7749	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia DUE TO Surgical myelomastosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) Surgical myelomastosis		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1, 1959 to 12/31, 1959 that I last saw the deceased alive on 12/31, 1959 , and that death occurred at 1:07 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen N. Jones M.D.		ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 12/31/59	
PHYSICIAN'S NAME (Type) Stephen N. Jones			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN. 4, 1960	22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	22d. LOCATION (City, town, or county) (State) WHEATON MD.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Taltrow		24a. REC'D BY REGISTRAR DATE JAN 5 '60	
ADDRESS 3603 14th St NW		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13903

Reg. Dist. No.

13949

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2212 Cobbleton Dr</u>				d. STREET ADDRESS <u>4838 Bradbrook Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arnold</u> Middle <u>Bennett</u> Last <u>McKee</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-1898</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u>	IF UNDER 24 HRS Hours <u>22</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C</u>	
13. FATHER'S NAME <u>William C. McKee</u>				14. MOTHER'S MAIDEN NAME <u>Adelaide Bennett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT Address <u>Georgeanna McKee-Item #2-Wife</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE, WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHECH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>12-22-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-26-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

MEDICAL CERTIFICATION

2

THIS MEDICAL EXAMINER'S CERTIFICATE OF DEATH should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page-4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

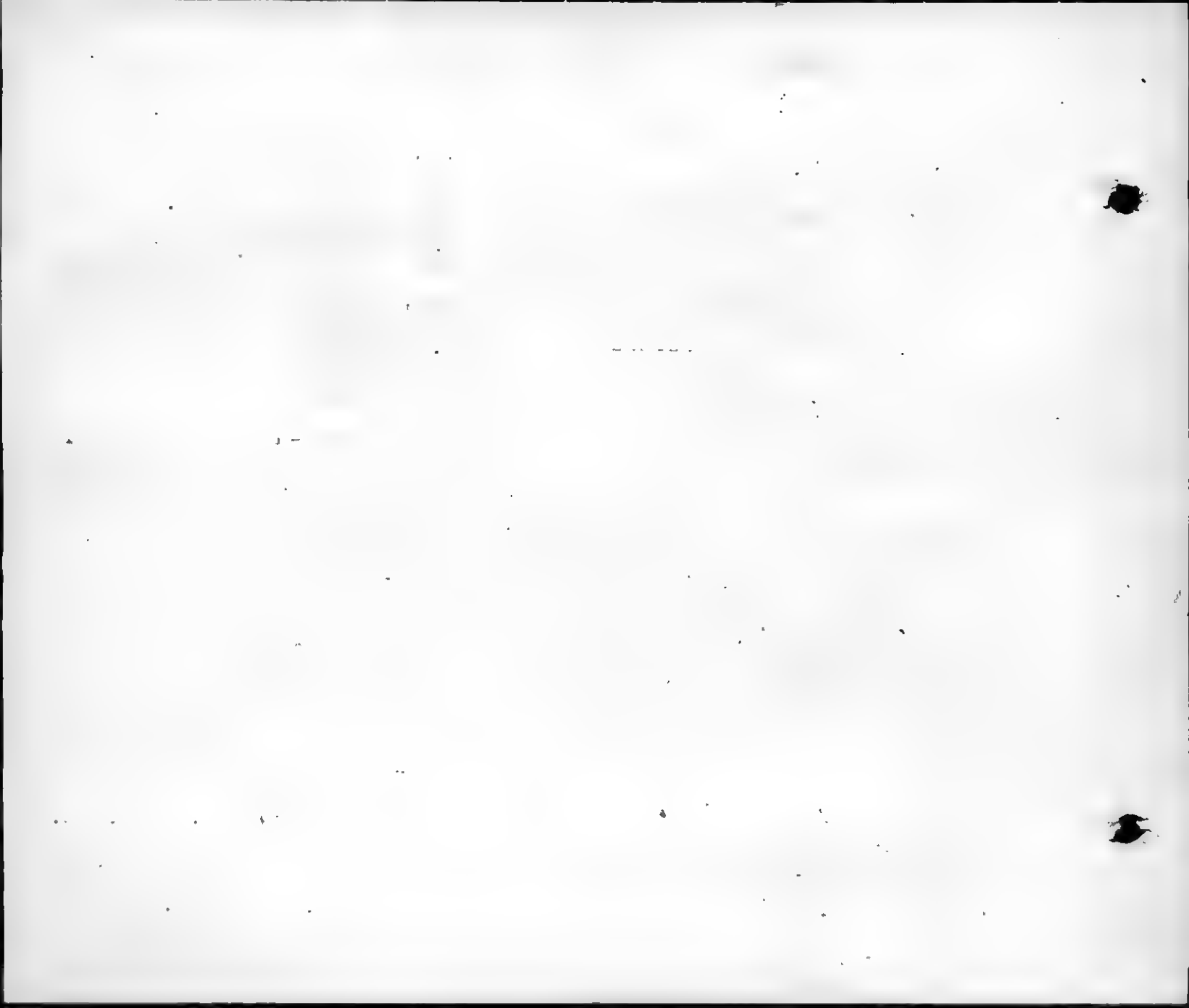
CERTIFICATE OF DEATH

Reg. Dist. No.

13910

13950

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8819 Kensington Parkway		d. STREET ADDRESS 8819 Kensington Pkwy.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last McLendon		4. DATE OF DEATH Month Dec. Day 22 Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1878	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 9 Days 13	11. IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		
11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Robert F. Carnes		14. MOTHER'S MAIDEN NAME ? Shaw		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		
INFORMANT Virginia Pendleton-daughter-same 2d		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Aneurysm of Abdominal Aorta 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Vascular Disease - DUE TO (c) Arteriosclerosis - generalized -				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr. 10 yr. 20 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary insufficiency -				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Jan. , 19 57 , to date , 19 59 , that I last saw the deceased alive on 22 Dec. , 19 59 , and that death occurred at 3:15 M, from the causes and on the date stated above.				
ACTUAL SIGNATURE John G. Ball		ADDRESS (Street, city or town, state) DATE SIGNED M.D. 7936 Old Georgetown Rd. Beth. Md. 12/22/59		
PHYSICIAN'S NAME (Type) John G. Ball				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/59		
22c. NAME OF CEMETERY OR CREMATORY Bishopville Cem		22d. LOCATION (City, town, or county) (State) Bishopville, S. Carolina		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		
24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE Orlana S. Kraus		



13848

CERTIFICATE OF DEATH

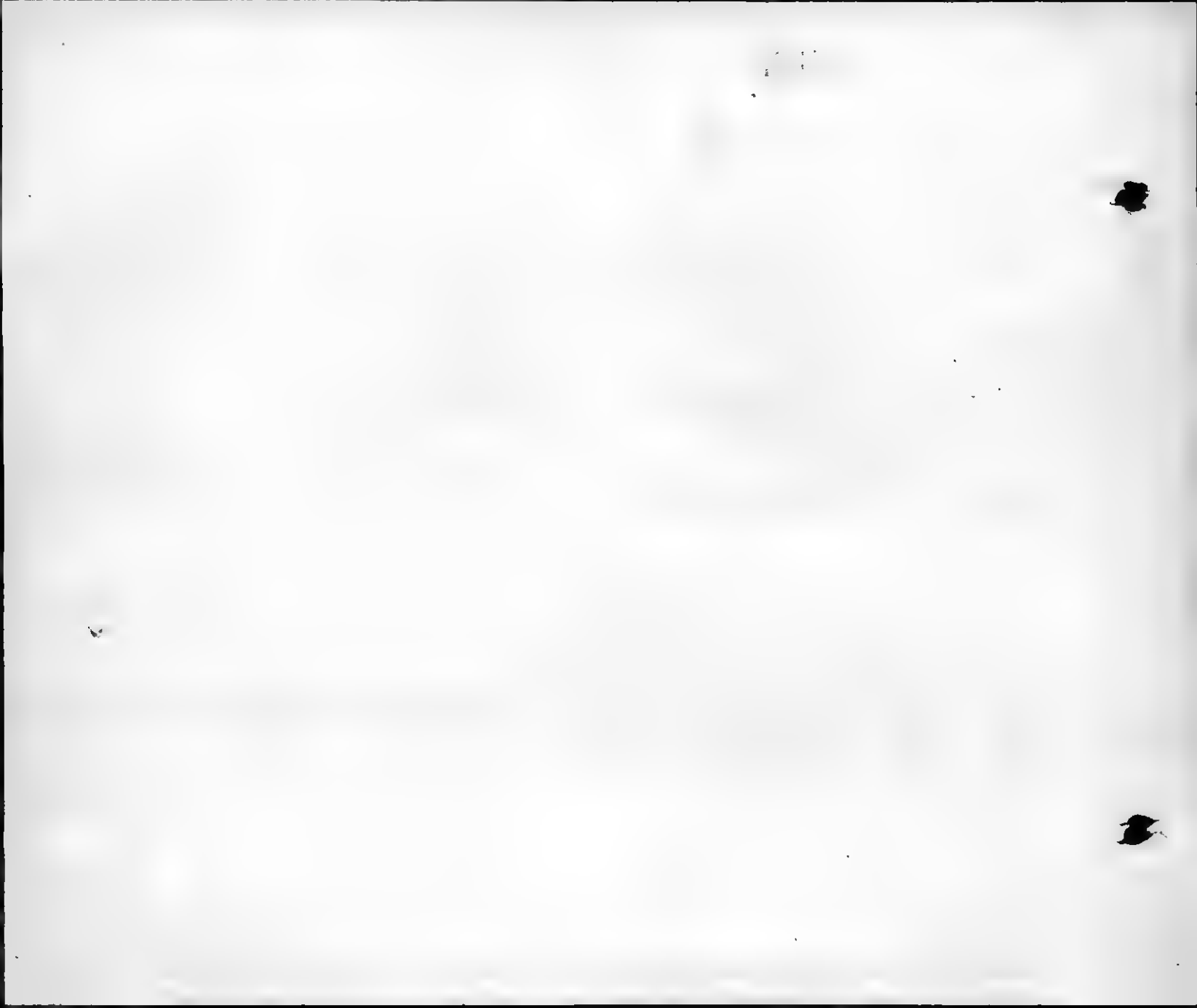
Reg. Dist. No.

13911

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dr. Willard Payne McNeill</u>				4. DATE OF DEATH Month Day Year <u>Dec. 28 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-10</u>	9. AGE (In years last birthday) <u>49 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Essex Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Stanley E. McNeill</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>198.2 Dilatation & Bursal Undifferentiated</u> DUE TO <u>will</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>infection of the Brain</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/24</u> , 19 <u>57</u> , to <u>12/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/28</u> , 19 <u>59</u> , and that death occurred at <u>4:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600 Laurel Cove Takoma Park</u> DATE SIGNED <u>12/28/59</u> ACTUAL SIGNATURE <u>Chas H Wolohan</u> M.D. PHYSICIAN'S NAME (Type) <u>Chas H Wolohan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 2-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Jackson Farm Hyattsville Prince Georges Co. Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		ADDRESS <u>WASH 13 D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 30 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 111-6254 1-13-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13912

13951

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b Washington d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmore Sanitarium		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 415 6th st. N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sue Middle T. Last Michie		4. DATE OF DEATH Month Dec Day 29 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/12/1876
9. AGE (In years lost birthday) 83 yrs		10. IF UNDER 1 YEAR Months 8 Days 3 Hours 0 Min.	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Lane		14. MOTHER'S MAIDEN NAME Mary Twaddell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Col. J. W. Twaddell		16. SOCIAL SECURITY NO. 2778 Wakefiled	
17. INFORMANT Arlington, Va.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Streptococcus abscess 053.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cardio vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY *Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1959 to Dec 29 1959 that I last saw the deceased alive on Dec 29 1959 and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1822 Biltmore St. N.W. Washington D.C. DATE SIGNED Dec 31 1959			
ACTUAL SIGNATURE E. B. Quayle		M.D. 1822 Biltmore St. N.W. Washington D.C.	
PHYSICIAN'S NAME (Type) E. B. Quayle		Washington D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/2/60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lea Funeral Home		24a. REC'D BY REGISTRAR 300-4th St. N.E. Wash DC	
24b. REGISTRAR'S SIGNATURE DEC 31 1959		24c. REGISTRAR'S SIGNATURE DEC 31 1959	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 wk</u>		d. STREET ADDRESS <u>11919 Andrews St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11919 Andrews St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thelma D. Miller</u>		4. DATE OF DEATH <u>Dec 8 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Harry Dock</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dated of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Suburban Hosp. record - Bethesda md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hospitalized 17 days for thrombosis left iliofemoral vein</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Bloesch</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BLOESCH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-8-59</u>	
22a. BURIAL, CREMATORY, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> ADDRESS <u>4812 W. Ave</u>		24a. REC'D BY REGISTRAR <u>DEC 15 '59</u>	
24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted in 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No.

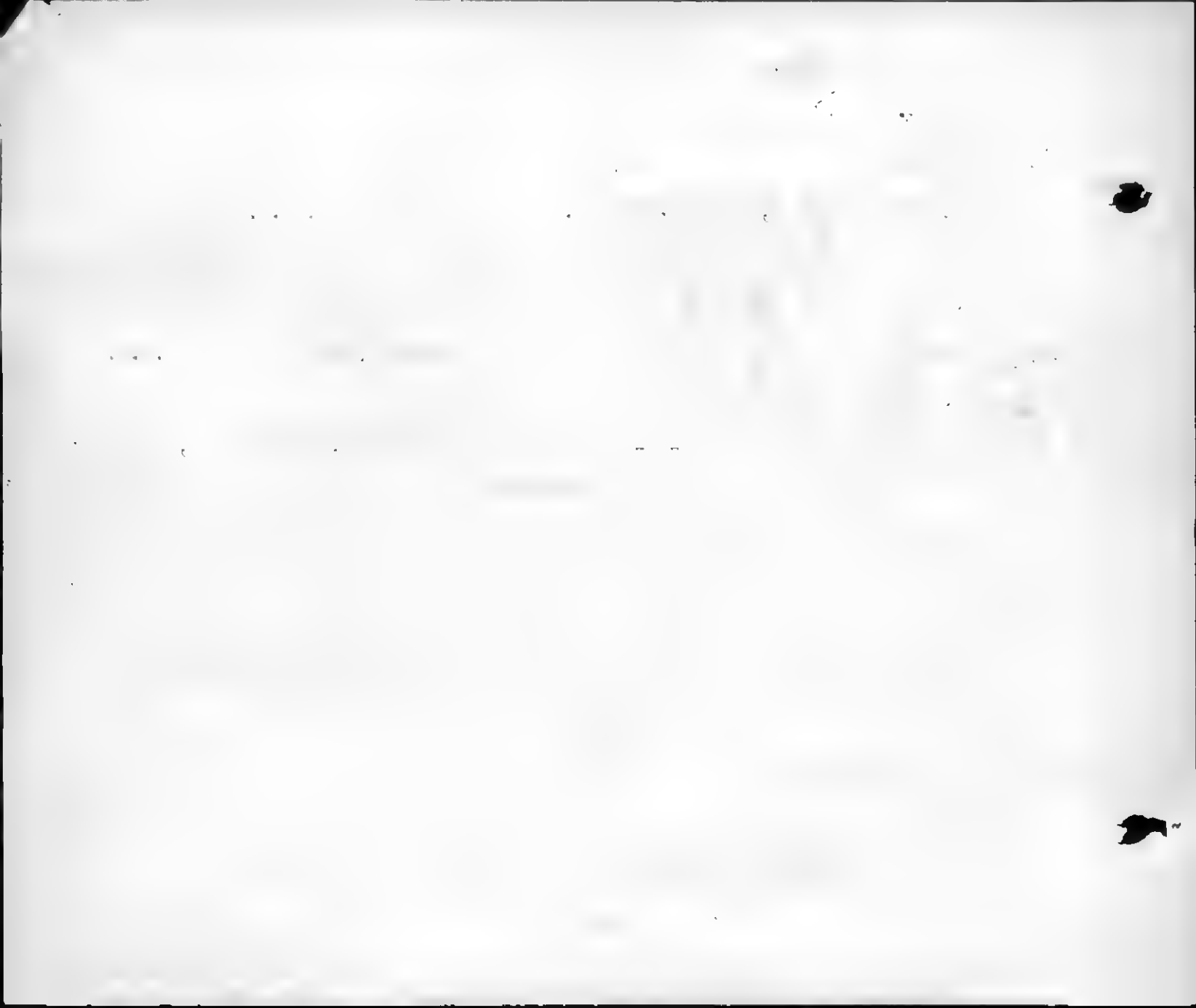
13914

13953

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>Minnie</u> Last <u>Mitchell</u>				4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 June 1888</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Etta Hunt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-22-1892</u>			
INFORMANT <u>The Medical Record</u>				Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Obstruction</u> DUE TO <u>41.4</u> Aspiration of blood from oral hemorrhage 5 minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of tongue with metastases</u> DUE TO <u>3 months</u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>December 21, 1959</u> , to <u>December 27, 1959</u> , that I last saw the deceased alive on <u>December 27, 1959</u> , and that death occurred at <u>1:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard S. Schwartz</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD S. SCHWARTZ</u>				DATE SIGNED <u>12/27/59</u>			
22a. B. J. R. L. CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-30-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) <u>Arlington, Va.</u>				22e. (State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. Chambers Co. Inc. Wash. D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OF BATHING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13915

Reg. Dist. No.

13954

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andover</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>				d. STREET ADDRESS <u>15360 Colesville Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andover Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas William Moore</u>				4. DATE OF DEATH Month Day Year <u>Dec 8 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-6-1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Pat Moore</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-27-4407</u>			
17. INFORMANT <u>Constance Moore (wife)</u>				Address <u>Slm 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 11, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St, Bk 16</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 10 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13916

CERTIFICATE OF DEATH

Reg. Dist. No.

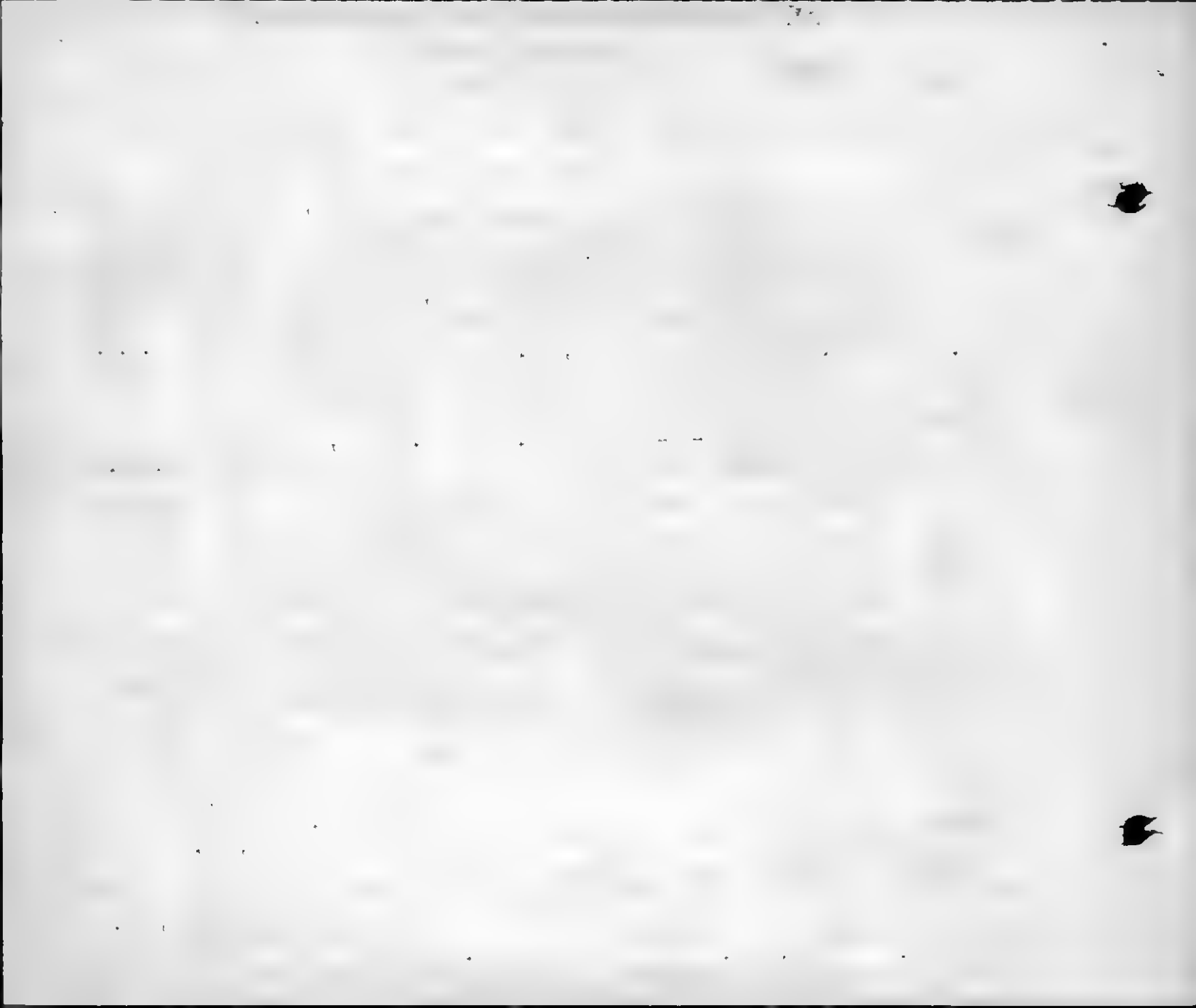
13955

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDEAU NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 8316 Carey Lane, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PETER Middle JOSEPH Last MORIN		4. DATE OF DEATH Month 12 Day 10 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 12 Days 10 Hours 19 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Meat Dept.		11b. KIND OF BUSINESS OR INDUSTRY Safeway Stores, Inc.	
11. BIRTHPLACE (State or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME XAVIER MORIN		14. MOTHER'S MAIDEN NAME PHILOMENA GAUTIER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-09-2717	
17. INFORMANT Mrs. Regina M. Morin,		Address 8316 Carey Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Terminal bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 days several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-26 19 59 , to 12-10 19 59 , that I last saw the deceased alive on 12-9 19 59 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jason Geiger		ADDRESS (Street, city or town, state) 931 Pershing Dr. Silver Spring, Md.	
DATE SIGNED 12-11-59			
PHYSICIAN'S NAME (Type) JASON GEIGER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/14/59	
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DEC 16 '59		24b. REGISTRAR'S SIGNATURE James L. Hanes	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

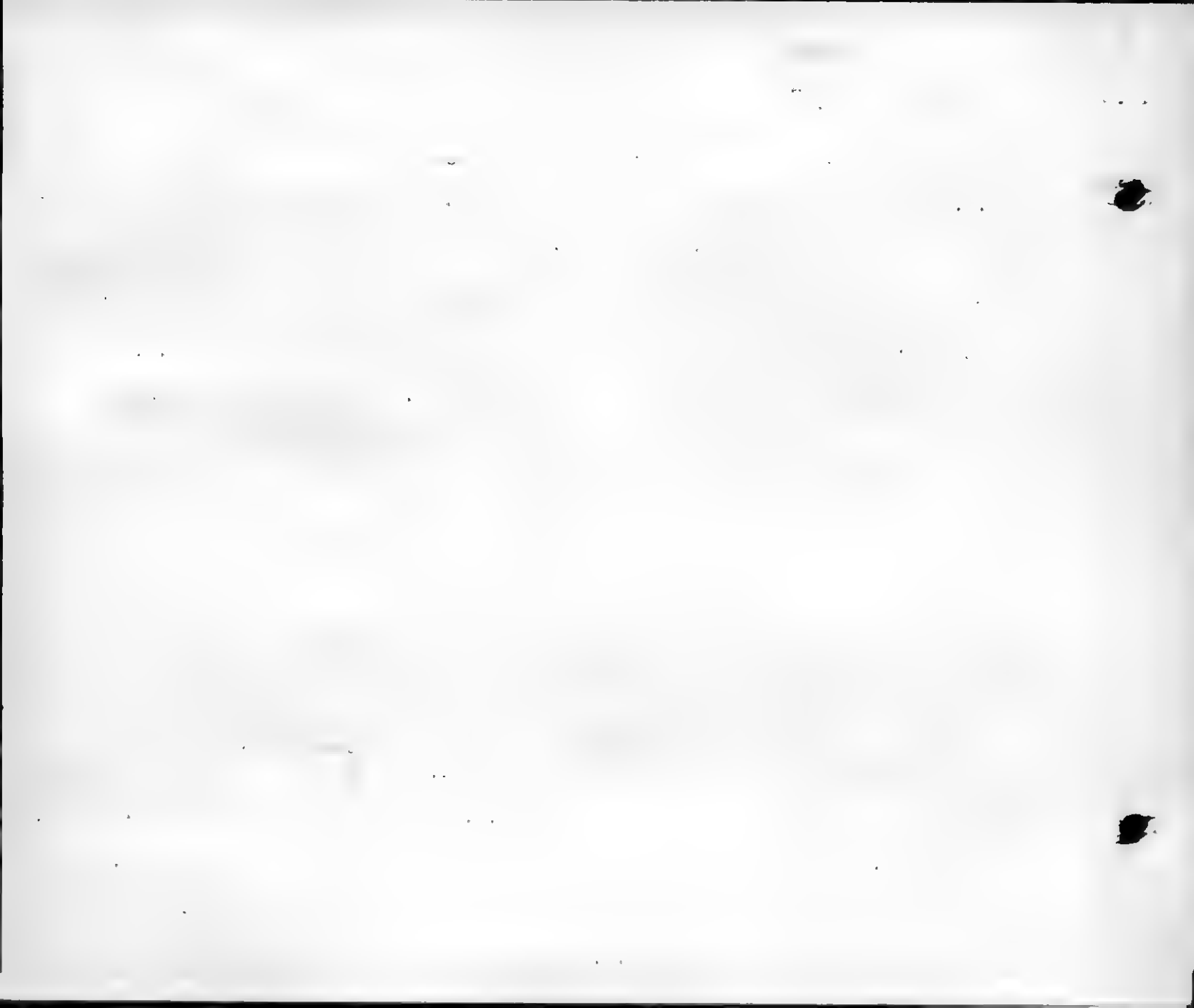
13917

13956

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 65 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital NNM		2 USUAL RESIDENCE (Where deceased lived F institution Residence before admission) a. STATE Florida b. COUNTY Key West c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 d. STREET ADDRESS Avenue E Big Coppitt Key e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Dorothy Lorraine Mosier		4 DATE OF DEATH Month Day Year December 12 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 May 1924
9 AGE (In years lost birthday) 35 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) Conn.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Barney Belgrade		14. MOTHER'S MAIDEN NAME Rose Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Papillary Serous Cyst Adeno Carcinoma DUE TO (c) 6 MOS.		INTERVAL BETWEEN ONSET AND DEATH 6 MOS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that I attended the deceased from 8 October 19 59 to 12 December 19 59 that I last saw the deceased alive on 12 December 19 59 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. 12-14-59 DATE SIGNED ACTUAL SIGNATURE R.H. Perkins M.D. U.S. Naval Hospital, Bethesda Md. PHYSICIAN'S NAME (Type) R.H. PERKINS LT MC USN U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-59	
22c. NAME OF CEMETERY OR CREMATORY Jewish Cemetery		22d. LOCATION (City, town, or county) (State) Waterford Conn.	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home Washington, D.C. 4812 9th Ave		24a. REC'D BY REGISTRAR DATE DEC 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			



13957

CERTIFICATE OF DEATH

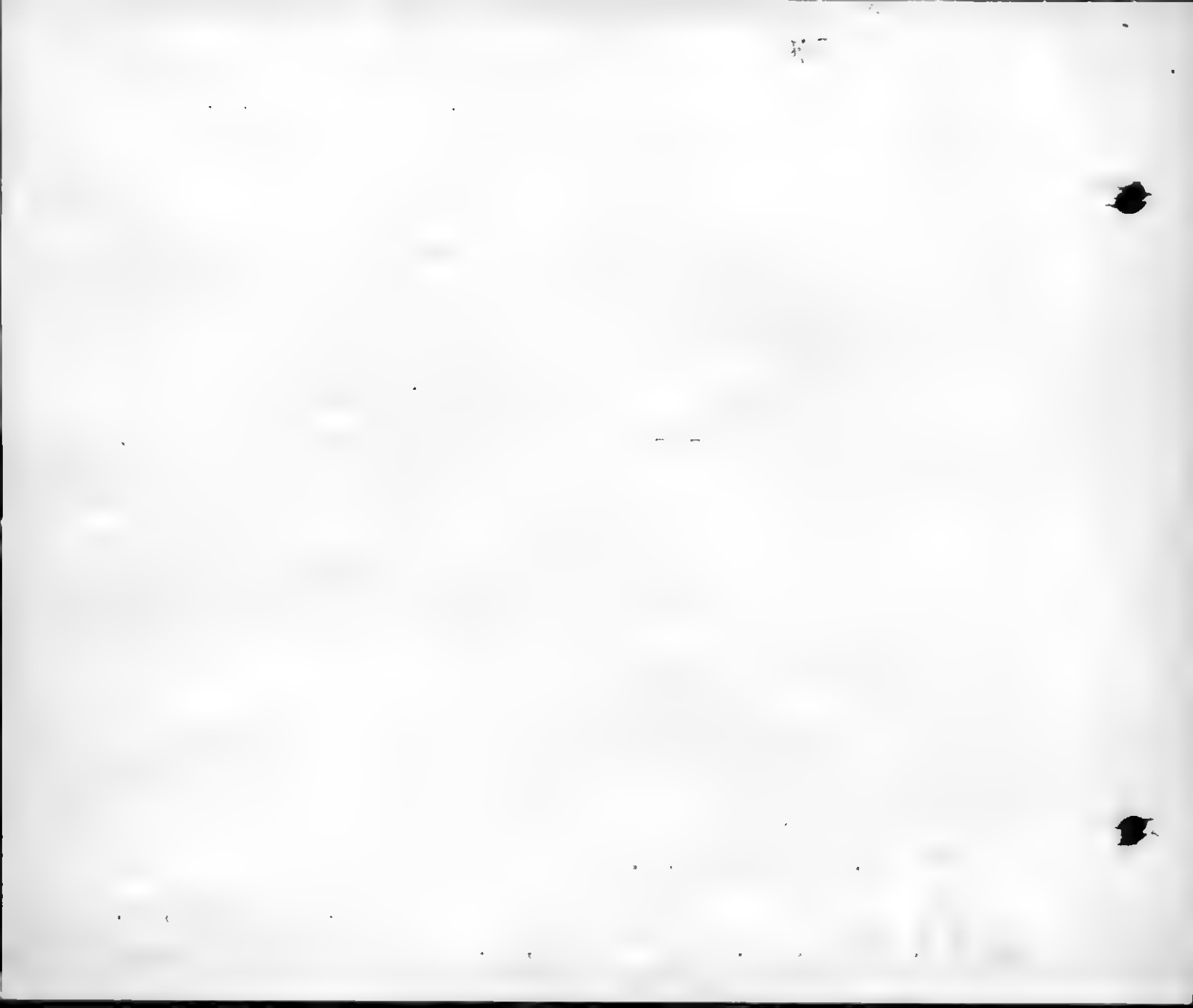
13918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 8 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KENSINGTON		d. STREET ADDRESS 3932 WASHINGTON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CLARENCE MOULDEN		4. DATE OF DEATH Month Day Year DECEMBER 29 19 59		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/26/77		9. AGE (In years last birthday) 82 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat cutter and Clerk		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH MOULDEN		14. MOTHER'S MAIDEN NAME ANNIE BREMMIMAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-01-6764		INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Asphyxiation, Coronary Artery Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														INTERVAL BETWEEN ONSET AND DEATH 7 days 13 yrs					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that I attended the deceased from 12/21 , 19 59 , to 12/29 , 19 59 , that I last saw the deceased alive on 12/29 , 19 59 , and that death occurred at 11:22 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE A. D. Bonifant M.D. _____ PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D. SANDY SPRING, MARYLAND																			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/2/60		22c. NAME OF CEMETERY OR CREMATORY ROCKVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.													
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPERY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JAN 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

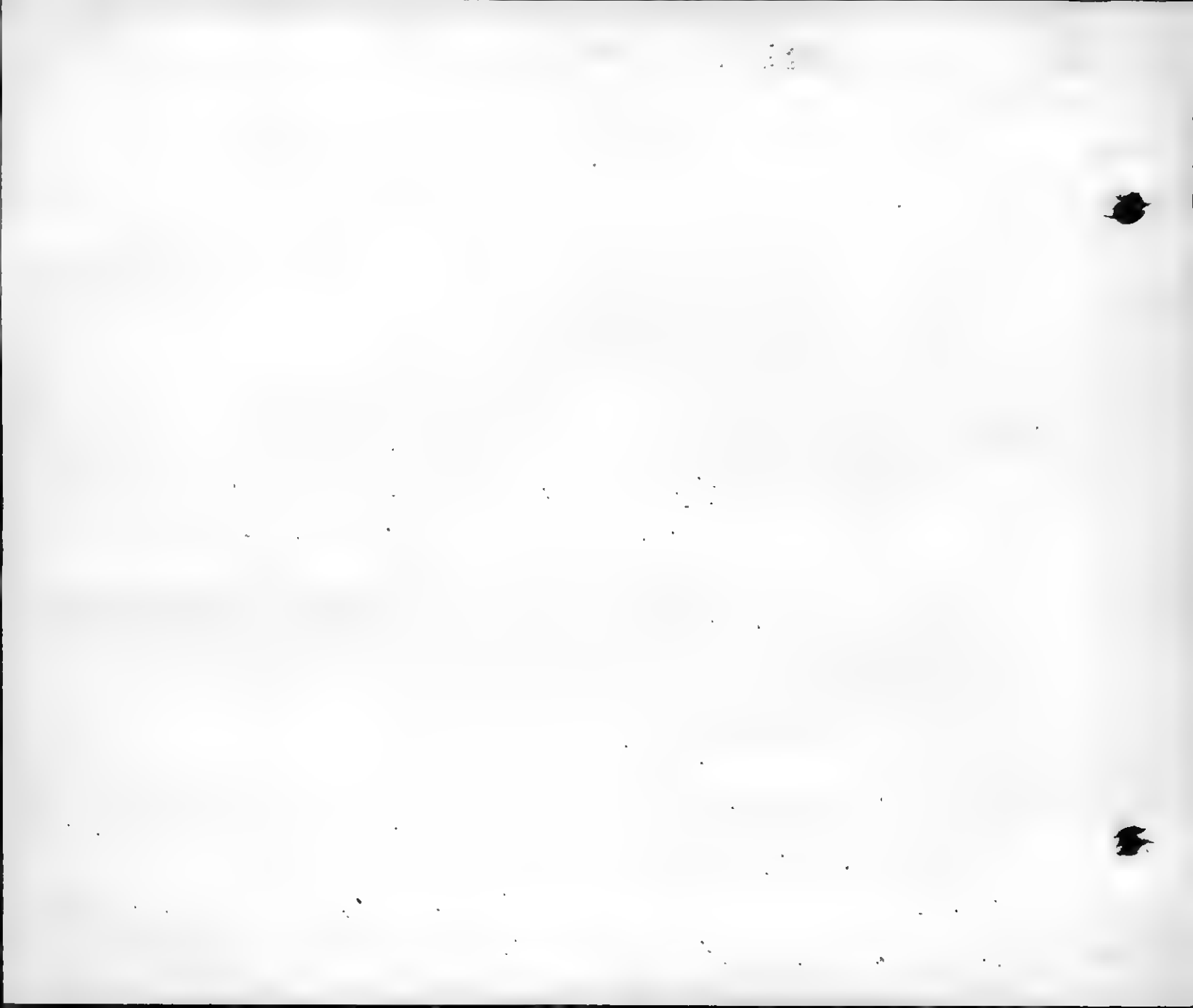
13958

CERTIFICATE OF DEATH

Reg. Dist. No.

13919

1. PLACE OF DEATH a. COUNTY M ontgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY M ontgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 12 Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
f. STREET ADDRESS 6900 M illwood Rd.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle E. Last M uldoon				4. DATE OF DEATH Month Dec. Day 3 Year 1959			
5. SEX M ale	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/85	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min.	IF UNDER 24 HRS Months 74 Days 74 Hours 74 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Thomas M uldoon				14. MOTHER'S MAIDEN NAME Kennedy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		INFORMANT Address Son) Burke M uldoon (same as Above)			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151x DUE TO Generalized Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastric Carcinoma (c) Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12 p. m. 12				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/16 , 19 59 , to 12/3 , 19 59 , that I last saw the deceased alive on 12/2 , 19 59 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald G. Ekman M.D.				ADDRESS (Street, city or town, state) 5767 Wisconsin Ave Chevy Chase, Md DATE SIGNED 12/3/59			
PHYSICIAN'S NAME (Type) Donald G. Ekman							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/5/59		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Am.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Cheng Chase Funeral Home				ADDRESS 5103 Wis Ave WASH D.C.		24a. REC'D BY REGISTRAR DATE DEC 7 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13849

CERTIFICATE OF DEATH

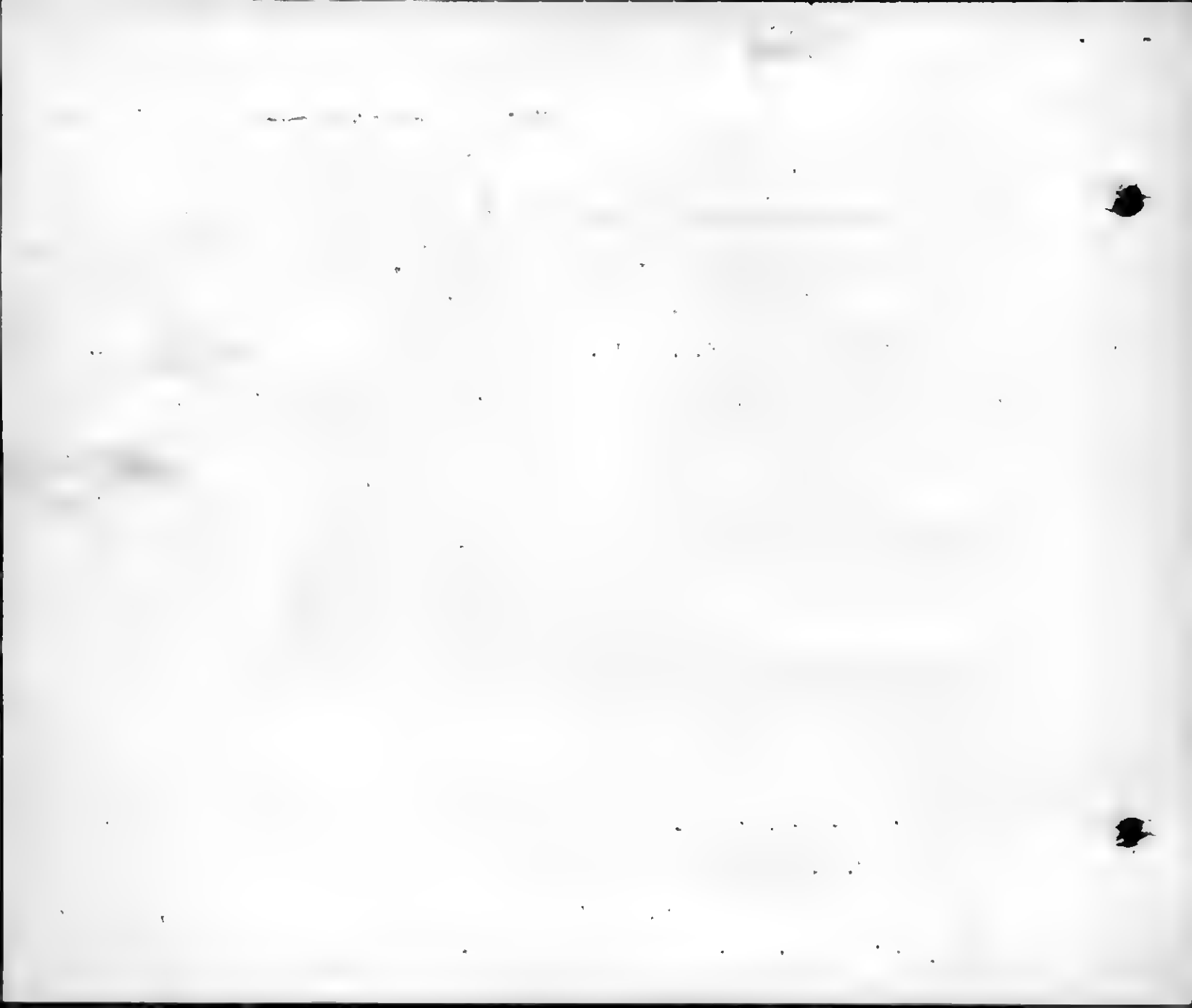
Reg. Dist. No.

13900

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitorium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Thomas James Murphy, SR</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/17/83</u>	9. AGE (In years last birthday) <u>76</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROPERTY MANAGER Govt Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Patrick C. Murphy</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Gilchen</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>106-34-88-5190-000</u>				17. INFORMANT <u>Daughter - 634 Sligo Ave.</u> Address <u>Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Disturbance</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>5 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 2</u> , 1959, to <u>Dec 29</u> , 1959, that I last saw the deceased alive on <u>Dec 29</u> , 1959, and that death occurred at <u>11:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. B. WARDROP</u> M.D.				ADDRESS (Street, city or town, state) <u>800 Pershing Drive</u> DATE SIGNED <u>12/29/59</u>			
PHYSICIAN'S NAME (Type) <u>W. B. WARDROP</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u> DATE <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13959

CERTIFICATE OF DEATH

Reg. Dist. No.

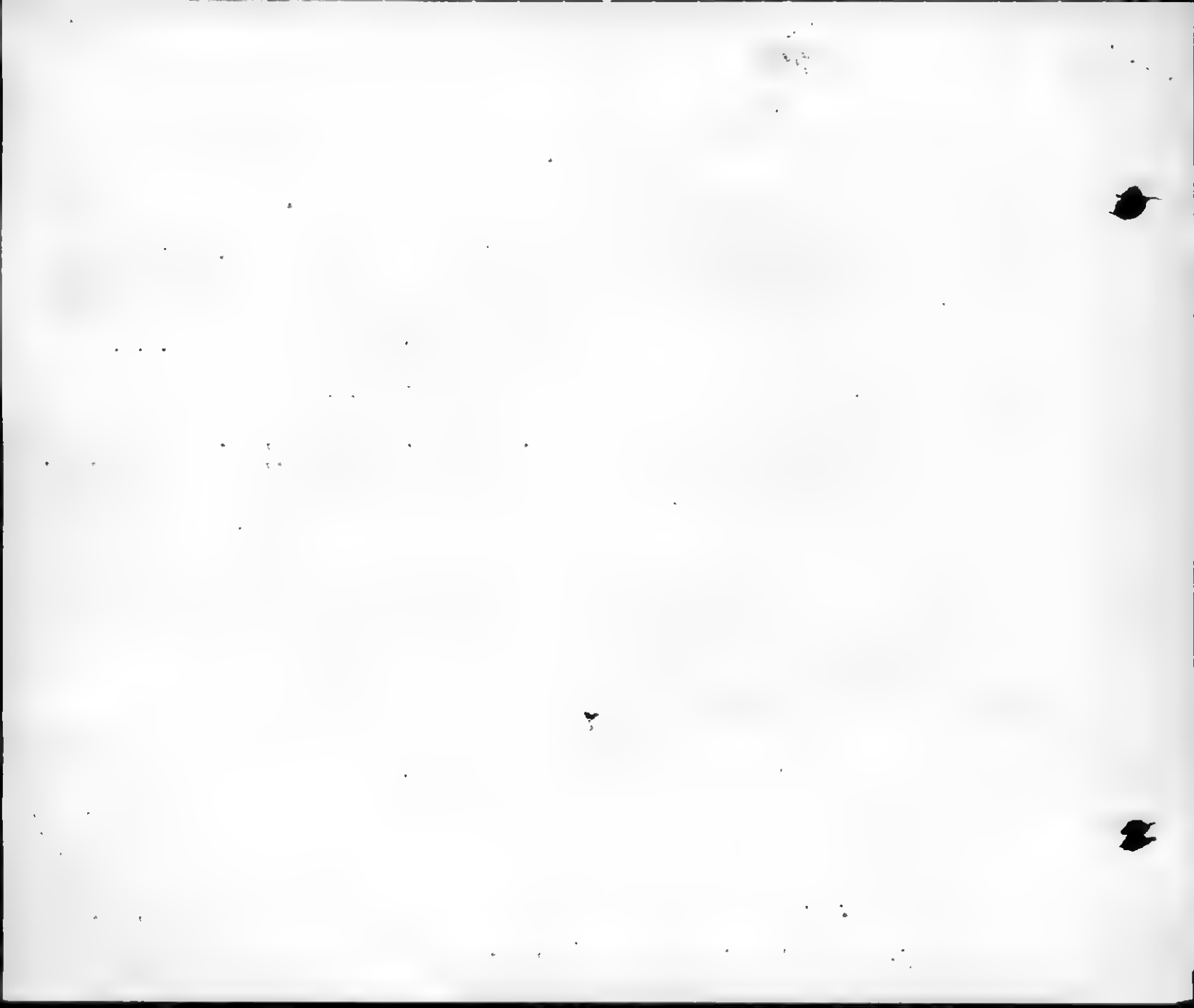
13921

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND		c. LENGTH OF STAY IN 1b 1 yr & 9 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle EMMA Last MUSGROVE		4. DATE OF DEATH Month DEC. Day 1 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/75
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Briggs		14. MOTHER'S MAIDEN NAME Frances Beckwith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Taylor O. Timberlake, Jr.		Address Briggs Chaney Rd., Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy, thrombotic DUE TO 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO 10 yrs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 1925 to Nov Dec , 1955 that I last saw the deceased alive on Nov 28 , 1955, and that death occurred at 1:15 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Md DATE SIGNED 12/1/59 ACTUAL SIGNATURE A. D. Bonifant M.D. Sandy Spring, Md PHYSICIAN'S NAME (Type) A. D. Bonifant			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/4/59	
22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DEC 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

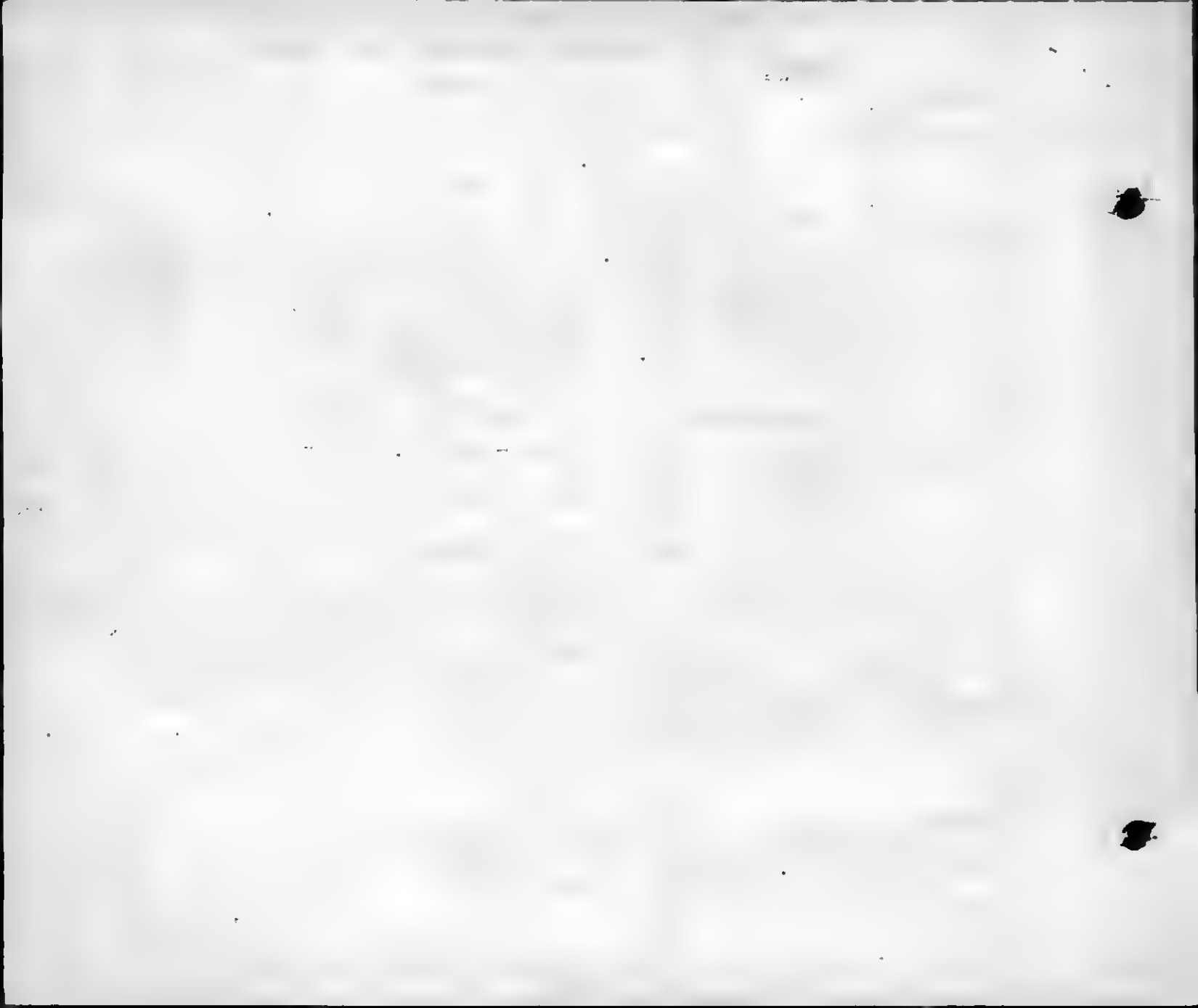
13942

Reg. Dist. No.

13960

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>33 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. STREET ADDRESS <u>5601 Greentree Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>G.</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/16/84</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief of Audits</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel Myers</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Hammond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Wife - Dolly T. Myers - same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fat embolism of lungs</u> <u>903.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of left femur</u> (c), stating the underlying cause last. DUE TO <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fe</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor at home</u>					
20c. TIME OF INJURY Month, Day, Year <u>12/18 19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank S. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank S. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/21/59</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

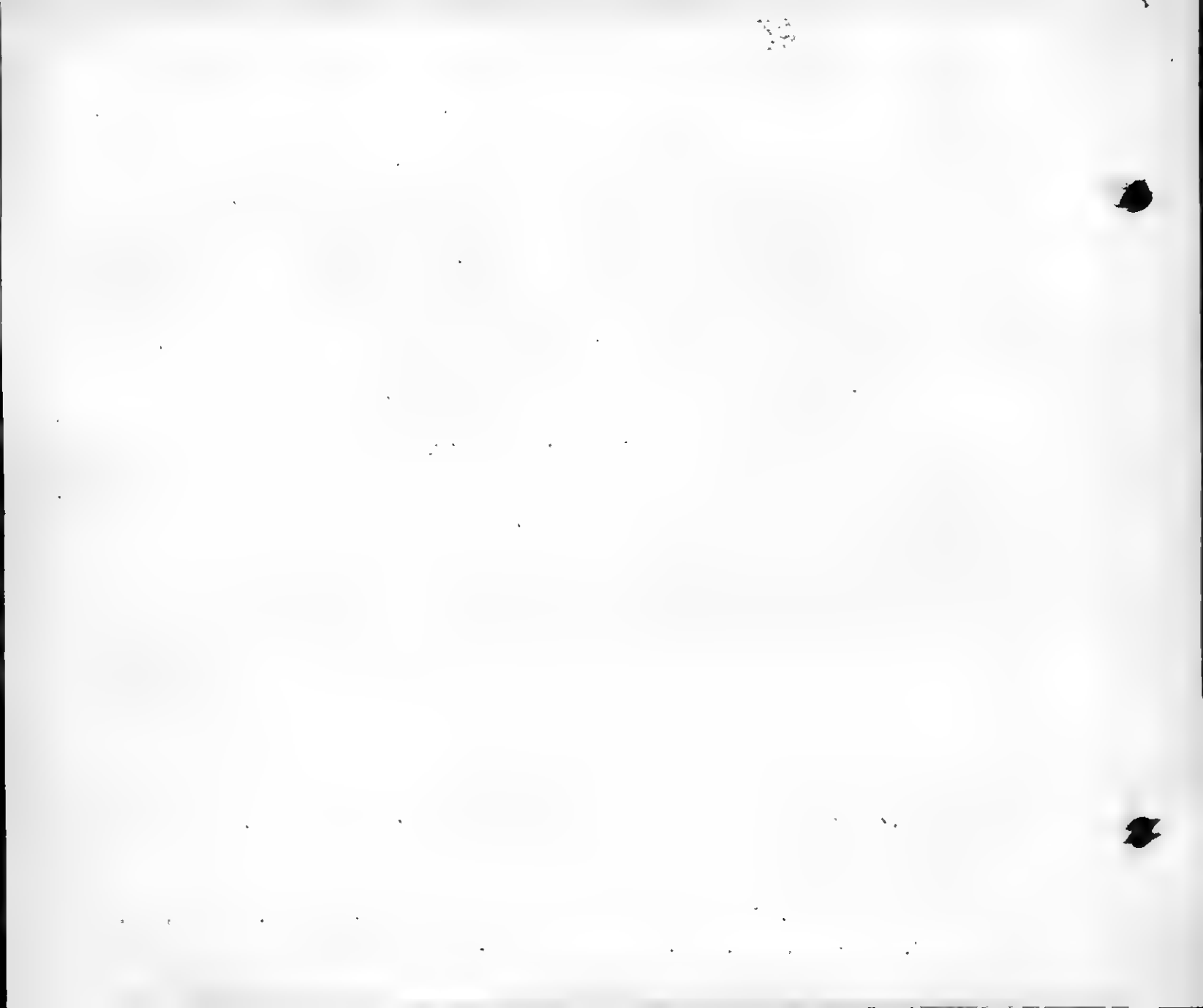
13961

CERTIFICATE OF DEATH

13923

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>25 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1018 WOODSIDE PARKWAY</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY</u> <u>EDGAR</u> <u>NAU</u>			4. DATE OF DEATH Month Day Year <u>DEC.</u> <u>29</u> <u>1959</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 25, 1889</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBING AND HEATING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own business PLUMBING</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>GEORGE H. NAU</u>			
14. MOTHER'S MAIDEN NAME <u>EMMA K. STOFFER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>577-07-9858</u>				INFORMANT <u>AMES, MARIE E. 1018 WOODSIDE PKWY MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA COLON WITH LIVER</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTASIS</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB. 16, 1955</u> to <u>DEC. 29, 1959</u> , that I last saw the deceased alive on <u>DECEMBER 29, 1959</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>JAMES A. ROBERTS</u> M.D. <u>8827 GEORGIA AVENUE</u> <u>12/29/59</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS M.D.</u> <u>SILVER SPRING, MARYLAND.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Zuck</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13962

CERTIFICATE OF DEATH

13924

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital NMMC				d. STREET ADDRESS 5605 19th ST North			
3. NAME OF DECEASED (Type or print) First Judith Middle Ann Last Nasipak				4. DATE OF DEATH Month December Day 13 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 August 1955	
9. AGE (In years lost birthday) 4 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Valentin Nasipak				14. MOTHER'S MAIDEN NAME Shirley Oliver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. INFORMANT Address (Father) Valentin Nasipak Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 180X IMMEDIATE CAUSE (a) Wilms Tumor, recurrent with metastases DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 13 December, 1959 , to 13 December, 1959 , that I last saw the deceased alive on 13 December, 1959 , and that death occurred at 0840A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 12-14-59							
ACTUAL SIGNATURE H.L. Walton				M.D. U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) H.L. Walton LT MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-59		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Elyria, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey				24a. REC'D BY REGISTRAR DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13963
CERTIFICATE OF DEATH

13925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery Co b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Md c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Althea Woodland Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 2022 Klinge Rd. N.W. b. COUNTY AD C ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47x d. STREET ADDRESS 2001 Waverly St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CeCelia Nelowich		4. DATE OF DEATH Month Day Year December 27, 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-17-1887
9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (State or foreign country) Russia	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Julius Zeckerman		14. MOTHER'S MAIDEN NAME Lena Zeckerman Light	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Gertrude Mensh 2022 Klinge Rd., N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Cerebro-vascular thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular dis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 18 m 16 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1957 to Dec. 27, 1959 that I last saw the deceased alive on Dec. 24, 1959, and that death occurred at 12:20 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Armand B. Gordon, M.D. 2828 Conn Ave, N.W. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Armand B. Gordon, M.D. Wash. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-29-59	
22c. NAME OF CEMETERY OR CREMATORY Adas Israel Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons 3501 14th St., N.W.		24a. REC'D BY REGISTRAR DATE DEC 30 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

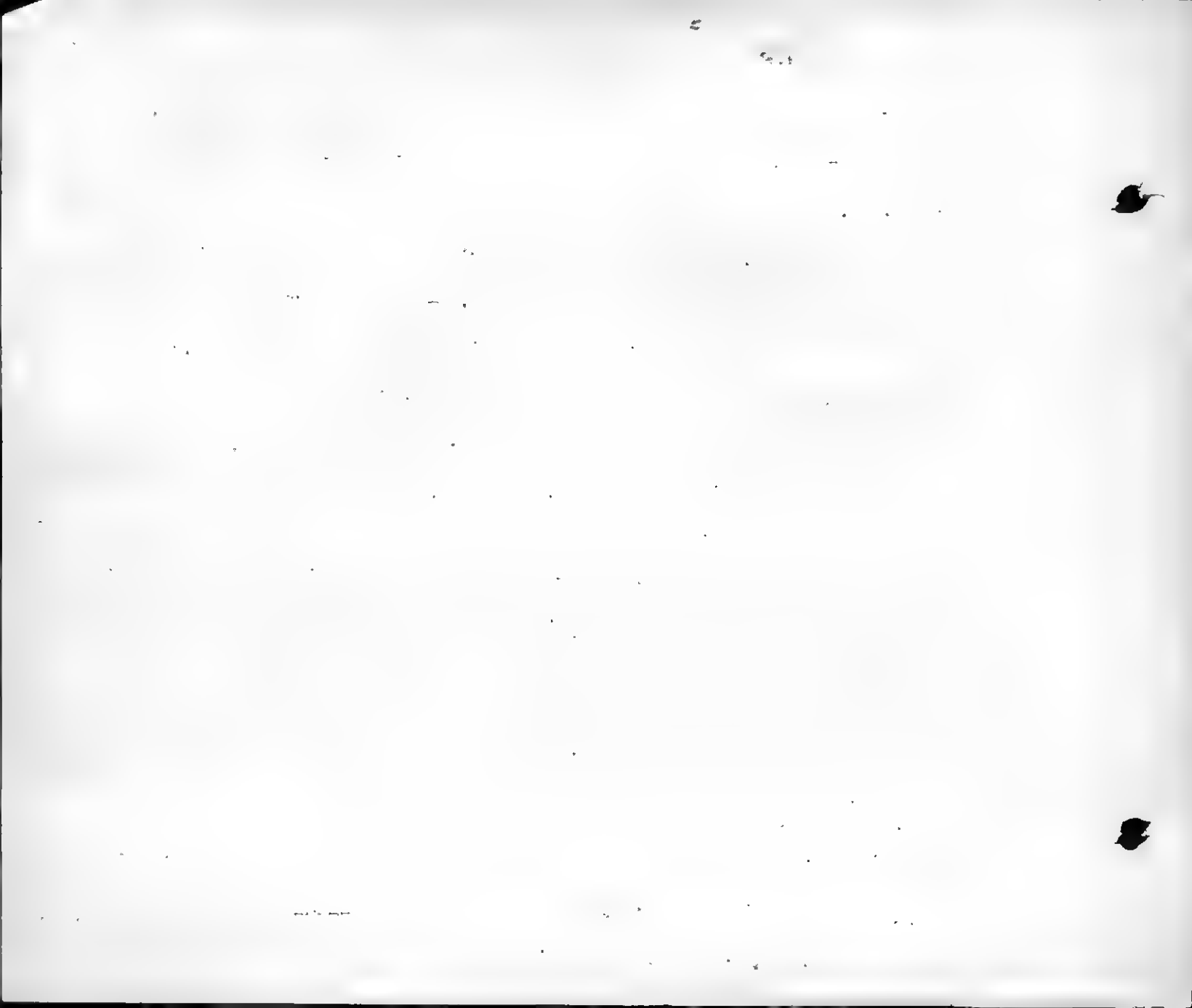
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13964 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN lb <u>3 hrs.</u>				d. STREET ADDRESS <u>15901 Aberdeen Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Judith</u> First <u>Vangrall</u> Middle <u>Nelson</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 11 1940</u>	
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>4</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>alf Z. Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Mary Vogt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Father</u> Address <u>alf Z Nelson</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>825X</u> DUE TO <u>EXSANGUINATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>LACERATION * Rupture, Thoracic Aorta</u> DUE TO <u>Automobile Accident</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractures of RT Femur & Pelvis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Wanderer in car involved in auto accident</u>					
20c. TIME OF INJURY Month, Day, Year <u>Dec 12-19 1959</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosnan</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosnan</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-20-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-22-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Md.</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawbirt's Sons</u> ADDRESS <u>Washington, DC</u>				24a. REC'D BY REGISTRAR <u>DEC 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraser</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13906 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13928

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u> c. LENGTH OF STAY IN 1b <u>18 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brookville Rd</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u> d. STREET ADDRESS <u>Brookville Rd</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Margaret Sarah Nicholson</u> First Middle Last				4. DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1959</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-20-1890</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Samuel A. Gower</u>						14. MOTHER'S MAIDEN NAME <u>Rebecca Cypres</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edward Nicholson - Son-in-law</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic heart disease</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>12-19-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Dec. 22 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>				22d. LOCATION (City, town, or county) <u>Laytonsville</u> (State) <u>Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Woyce Barber</u> ADDRESS <u>Laytonsville, Md</u>						24a. REC'D BY REGISTRAR DATE <u>DEC 23 '59</u>		24b. REGISTRAR'S SIGNATURE							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

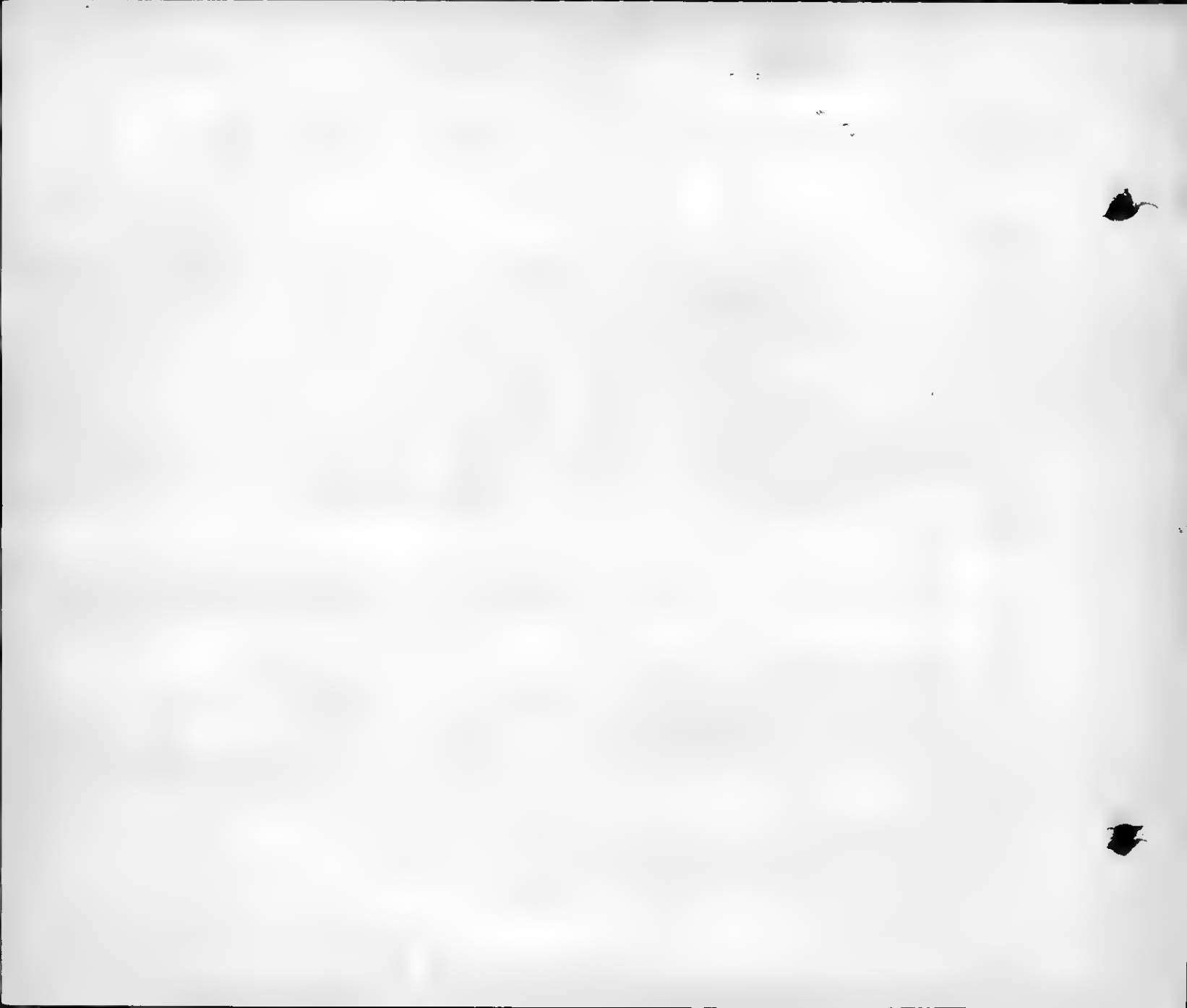
13850

CERTIFICATE OF DEATH

Reg. Dist. No.

13920

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Arlington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Haven Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>E</u> Last <u>Partello</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23, 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Frederick Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Wiles</u>		14. MOTHER'S MAIDEN NAME <u>Anne Wiles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William C Jarvis</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage of bowel</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of bowel</u> DUE TO (c) <u>with metastasis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 11, 1959</u> to <u>Dec 30, 1959</u> , that I last saw the deceased alive on <u>Dec 30, 1959</u> , and that death occurred at <u>10:18 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip C Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>918 Cedarwood Drive Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-4-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>JAN 4 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

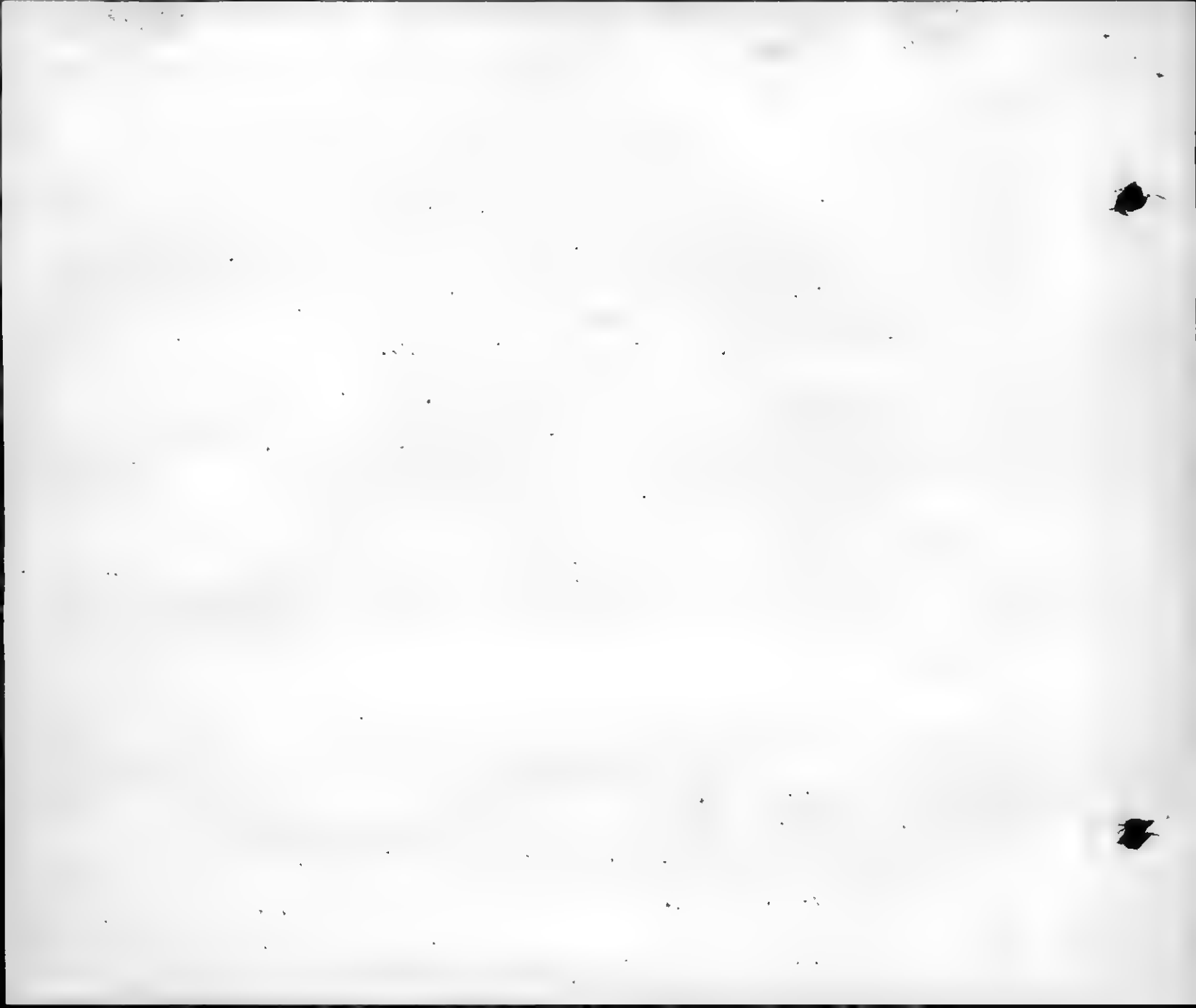


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13860
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 107 Aberdeen Rd.				d. STREET ADDRESS 107 Aberdeen Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) OLIVER H. PERRY				4. DATE OF DEATH December 23, 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/28/192	
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR 2 Months 25 Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Dealer				10b. KIND OF BUSINESS OR INDUSTRY Automobiles		11. BIRTHPLACE (State or foreign country) Wash., D.C.	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Ulyssus G. Perry				14. MOTHER'S MAIDEN NAME Clara D. Dean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW 1				16. SOCIAL SECURITY NO INFORMANT Address Dorothy M. Perry-Item# 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) Arteriosclerosis DUE TO (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							
INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 15 years 20 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 1945 to 12/23/59 , that I last saw the deceased alive on 12/23/59 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12/24/59							
ACTUAL SIGNATURE Wm. S. Murphy M.D.				DATE SIGNED 12/24/59			
PHYSICIAN'S NAME (Type) Wm. S. Murphy - W. Montg. Ave., Rockville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/59		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home ADDRESS 1331 E. Montgomery Avenue, Rockville, Md.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

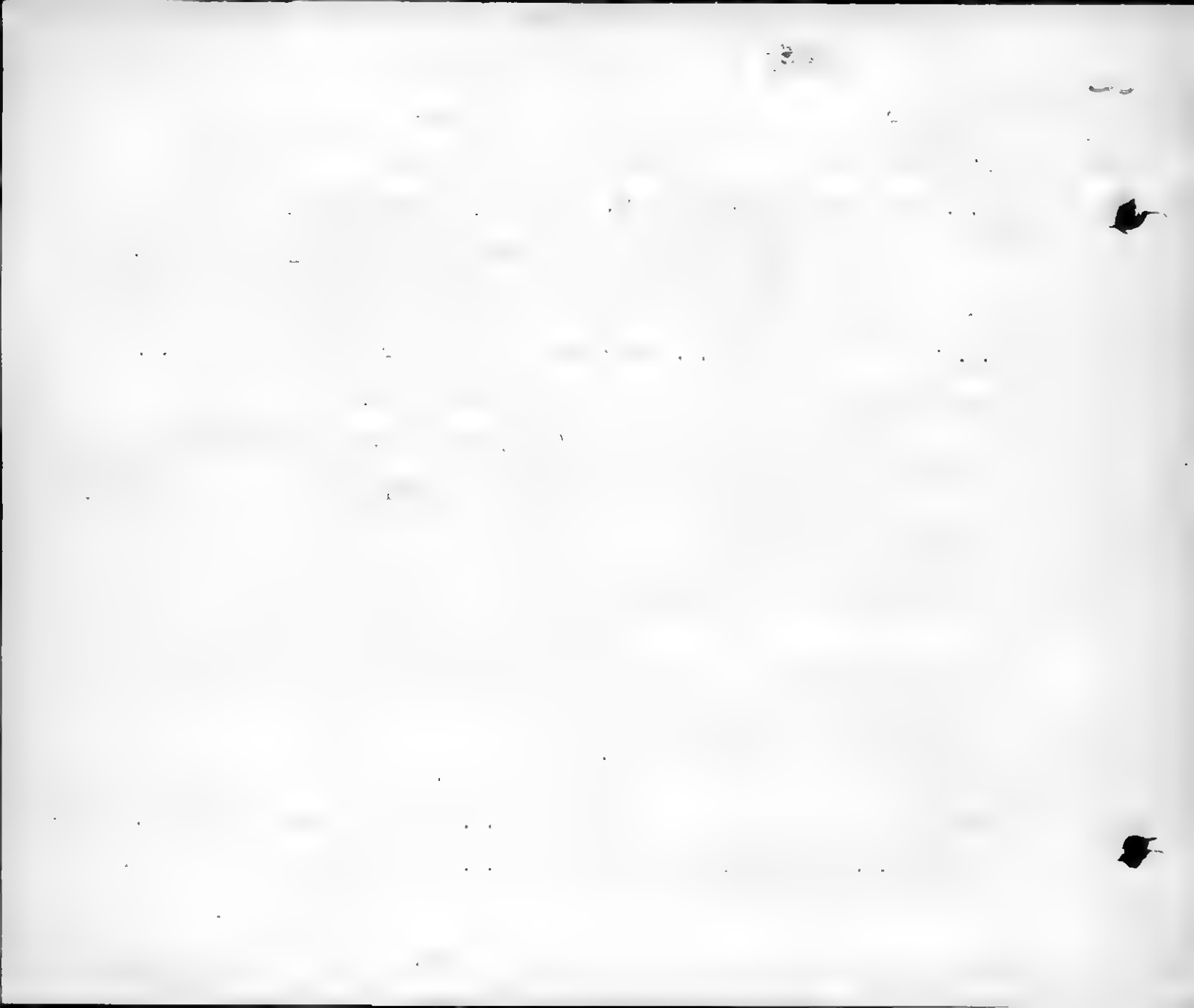


13967

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 57 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Clarence Last PIERCE				4. DATE OF DEATH Month December Day 19 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-22-14	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Albert PIERCE				14. MOTHER'S MAIDEN NAME Sarah CHAVES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes				16. SOCIAL SECURITY NO. INFORMANT (Wife) Dorothy M. Pierce Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retroperitoneal Liposcarcoma addomen 197.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 23 October , 19 59 , to 19 December , 19 59 that I last saw the deceased alive on 19 December , 19 59 , and that death occurred at 7:19P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 12-21-59 ACTUAL SIGNATURE Larry J. Hines M.D. PHYSICIAN'S NAME (Type) L.J. HINES LCDR MC USN U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 12-23-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's ADDRESS 4739 Baltimore Ave. Hyattsville Md.				24a. REC'D BY REGISTRAR DEC 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	



13968

CERTIFICATE OF DEATH

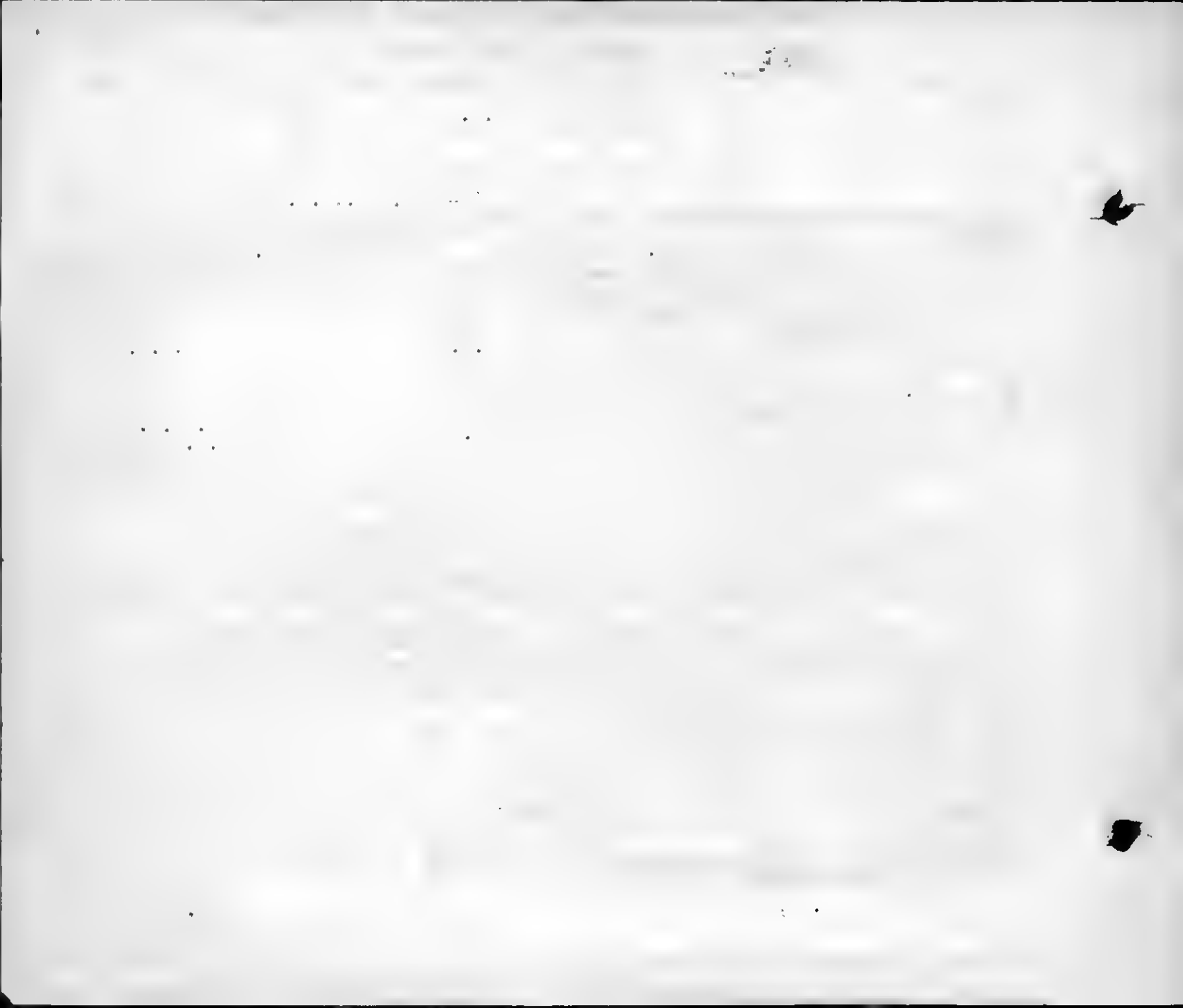
Reg. Dist. No.

13962

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Kensington Gardens Rest Home</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Rest Home</u>				d. STREET ADDRESS <u>5236-14th, St., N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>LADEL</u> First <u>I.</u> Middle <u>PUGH</u> Last				4. DATE OF DEATH <u>Dec., 12, 1959</u> Month <u>19</u> Day <u>19</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1890</u>	
9. AGE (In years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Abner P. Parker</u>				14. MOTHER'S MAIDEN NAME <u>Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Stanley S. Pugh</u> Address <u>5236-14th, St., N.W. Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Deside Generalized Arteriosclerosis</u> DUE TO (c) <u>Cerebral Sclerosis arteriolux</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abdominal Tumor - Liver Enlargement</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, Port I or Port II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>March, 1959</u> to <u>12-12, 1959</u> , that I last saw the deceased alive on <u>12-12, 1959</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>4201 Fessenden St. N.W. Washington D.C.</u>				DATE SIGNED <u>12-12-59</u>			
ACTUAL SIGNATURE <u>P.P. Andrews M.D.</u>							
PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 16, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Larkland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Pike, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13969

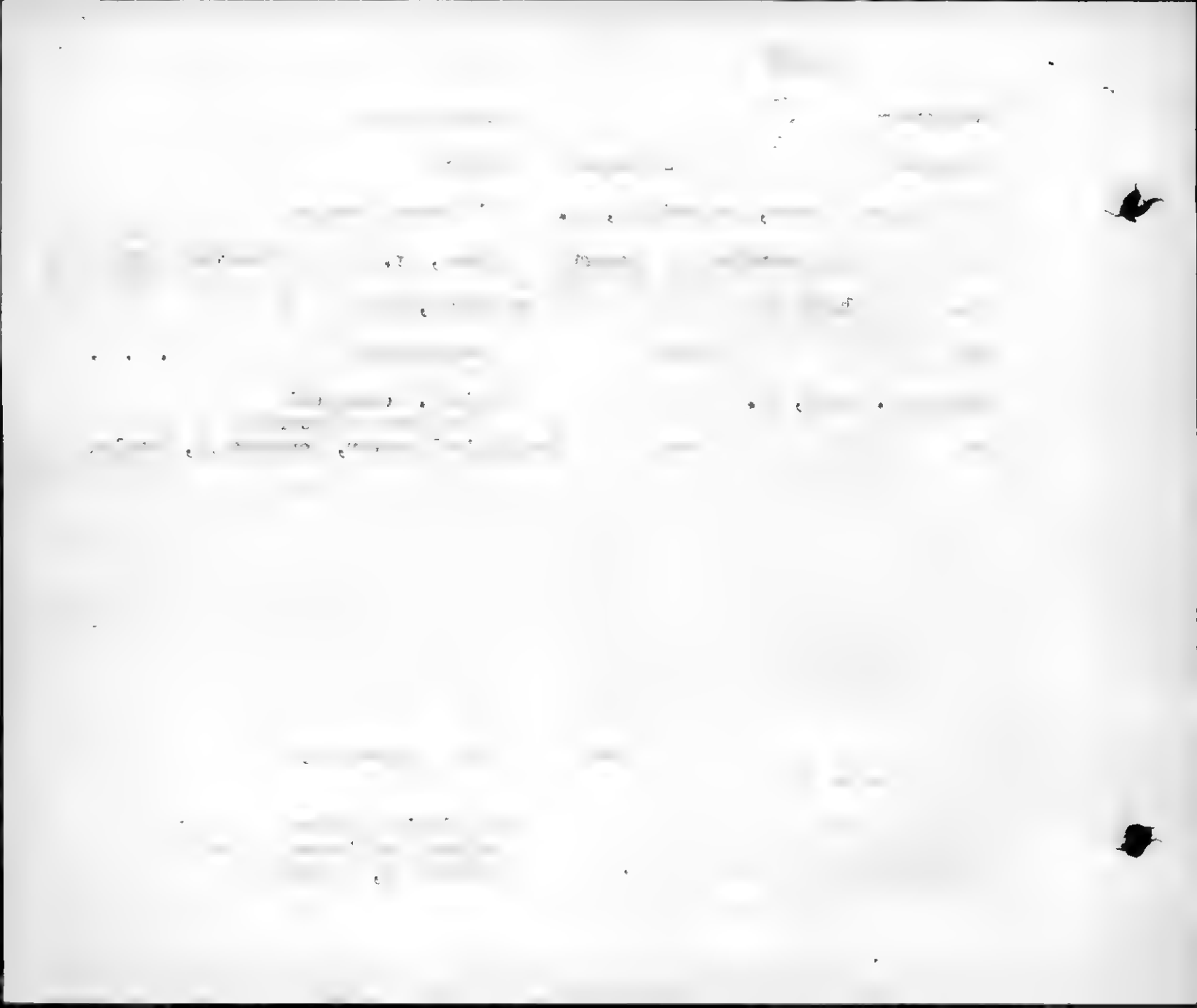
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 205 days			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Reading c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 501 Fomsten Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 501 Fomsten Avenue		
3. NAME OF DECEASED (Type or print) First Middle Last Kenneth Robert Rosch, Jr.			4. DATE OF DEATH Month Day Year December 30 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1954	9. AGE (In years lost birthday) 5 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10b. KIND OF BUSINESS OR INDUSTRY None		
11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Kenneth R. Rosch, Sr.			14. MOTHER'S MAIDEN NAME Doris M. Koleswrecki		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		
INFORMANT The Medical Record			Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastrointestinal Hemorrhage, Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 Months					INTERVAL BETWEEN ONSET AND DEATH 6 Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 8 , 19 59 , to December 30, 1959 , that I last saw the deceased alive on December 30 , 19 59 , and that death occurred at 10:00 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12-30-59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland					
ACTUAL SIGNATURE Lawrence A. Gaydos		M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) LAWRENCE A. GAYDOS, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/59	22c. NAME OF CEMETERY OR CREMATORY Lulenbach Cemetery		22d. LOCATION (City, town, or county) (State) Reading, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		
24a. REC'D BY REGISTRAR JAN 4 '60			24b. REGISTRAR'S SIGNATURE Arthur L. Korman		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13934

13970

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <u>MD</u> COUNTY <u>Northwest</u> 4811 4th Street, Northwest c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 472	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>October 30, 1959</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3000 McComas Avenue</u>		d. STREET ADDRESS <u>— — — —</u>	
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>H</u> Last <u>Robins</u>		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>— — — —</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander Eichwald</u>		14. MOTHER'S MAIDEN NAME <u>Celia Feirstein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>170X HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED METASTATIC CARCINOMA</u> (c) <u>CARCINOMA OF LEFT BREAST</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8-9 mos</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 10, 1957</u> to <u>12/10, 1959</u> that I last saw the deceased alive on <u>12/8, 1959</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold Sterling</u>		ADDRESS (Street, city or town, state) <u>1352 UNIVERSITY BLVD NASHVILLE, TN</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD STERLING-M.D.</u>		DATE SIGNED <u>12/10/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>DEC. 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETH EL</u>	22d. LOCATION (City, town, or county) (State) <u>NEW YORK</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Douglas & Sons</u>		ADDRESS <u>3501 14th St. N.W. WASH. D.C.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>DEC 14 '59</u>		<u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13851

CERTIFICATE OF DEATH

Reg. Dist. No.

13935

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> <u>16x</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>Beechhaven Farm</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Aquila Turner Robinson</u>				4. DATE OF DEATH Month Day Year <u>12 20 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-86</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Aquila T. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Sally P. Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>179</u>		INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>540.0</u> DUE TO <u>Peptic Ulcer-hemorrhaging</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>540.0</u> DUE TO <u>Peptic Ulcer-hemorrhaging</u> (c) <u>540.0</u> DUE TO <u>Peptic Ulcer-hemorrhaging</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>540.0</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 6, 1959</u> to <u>Dec 20, 1959</u> , that I last saw the deceased alive on <u>Dec 19, 1959</u> , and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>M.D. Takoma Park, Md.</u>		DATE SIGNED <u>12/24/59</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf Md</u>				24a. REC'D BY REGISTRAR <u>DEC 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carl S. K...</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1397 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13986

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>1 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10419 Mannakee St</u>			d. STREET ADDRESS <u>10419 Mannakee</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Barry</u> Last <u>Roche</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>7</u> Year <u>19 59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-1882</u>		9. AGE (In years last birthday) <u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retiree</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>
13. FATHER'S NAME <u>Michael Barry</u>			14. MOTHER'S MAIDEN NAME <u>Ellen Buckley</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jas. A Roche</u> Address <u>Stu</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>12-7-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
22d. LOCATION (City, town, or county) <u>Wash. D.C.</u>		22e. (State) <u>D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hanlon</u>			ADDRESS <u>3831-GA. Ave NW</u>		24a. REC'D BY REGISTRAR <u>DEC 18 59</u>
24b. REGISTRAR'S SIGNATURE					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13972

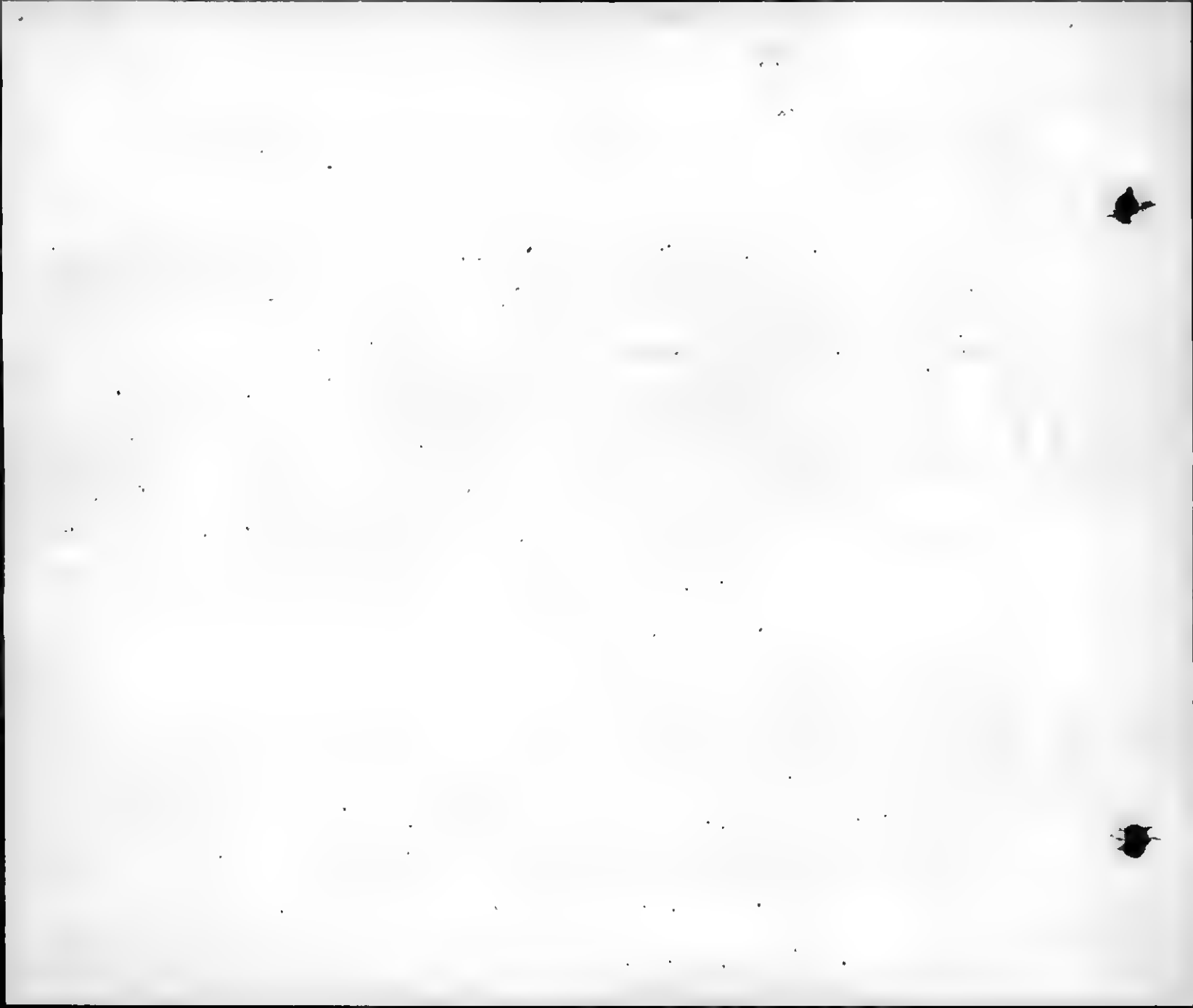
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Parkersville		c. LENGTH OF STAY IN 1b 18 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Route 28	
3. NAME OF DECEASED (Type or print) ALBERT GARFIELD ROLFE		4. DATE OF DEATH December 4 1959	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 28, 1932
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cattle farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME HENRY GEORGE ROLFE	
14. MOTHER'S MAIDEN NAME MARGARET BALDWIN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	
16. SOCIAL SECURITY NO. 578 05 8934		INFORMANT Marguerite R. Boggett, Alexandria, Va.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest 4:20.0 DUE TO 1st 2nd + 3rd degree heart block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last arteriosclerotic heart disease DUE TO arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema.		INTERVAL BETWEEN ONSET AND DEATH 3 years 3 years	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 20 Feb. 1956 to Dec 4 1959 , that I last saw the deceased alive on December 2, 1959 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE John G Fawcett M.D. Dorsonville		PHYSICIAN'S NAME (Type) JOHN G FAWCETT MD, P.O. Box D, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/4		22b. DATE THEREOF 12/4	
22c. NAME OF CEMETERY OR CREMATORY St. Chrysom Cemetery		22d. LOCATION (City, town, or county) Richmond, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Bliley, Jr. ADDRESS Richmond Va.		24a. REC'D BY REGISTRAR DATE 12/4/59	
24b. REGISTRAR'S SIGNATURE Arthur S. Fraw		DEC 7 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13973

CERTIFICATE OF DEATH

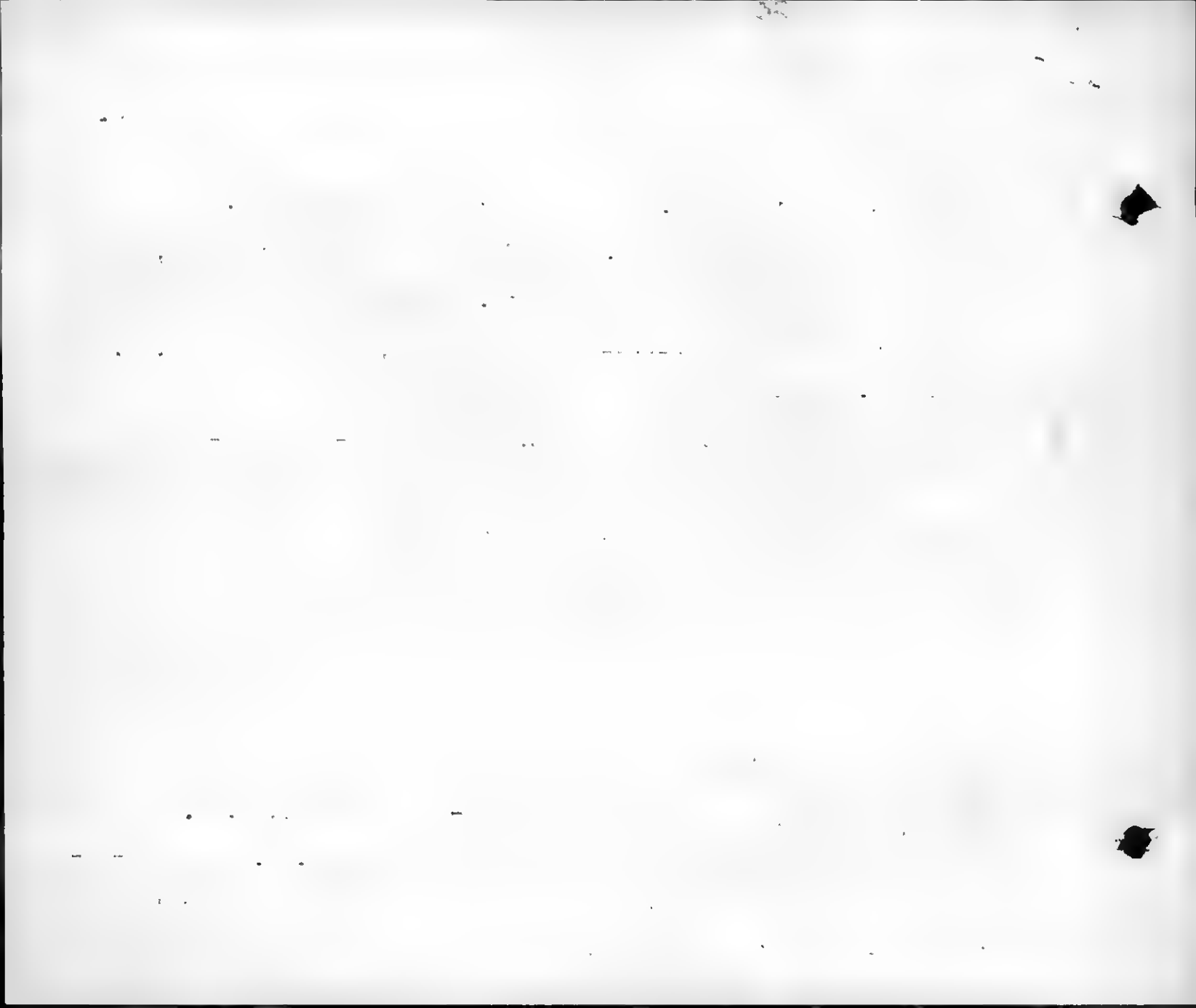
Reg. Dist. No.

13938

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b X Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4025 Jones Bridge Rd.		d. STREET ADDRESS 4025 Jones Bridge Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BLANCHE Middle S. Last ROUNDS		4. DATE OF DEATH Month DEC. Day 18, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 0 Days 4	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Richford, Vermont
12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Frank C. Sears		14. MOTHER'S MAIDEN NAME Addie Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Mrs. Henry Bloom-daughter-		Address same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized arteriosclerosis and Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO 		INTERVAL BETWEEN ONSET AND DEATH seventeen years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchial asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1948 19 18 , to Dec 18 , 19 59 , that I last saw the deceased alive on Dec 18 , 19 59 , and that death occurred at 6:30 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Saul Holtzman		DATE SIGNED 9000 17th Street, N. W. 12-19-59	
PHYSICIAN'S NAME (Type) Saul Holtzman		ADDRESS Washington, D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12/21/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DEC 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13852

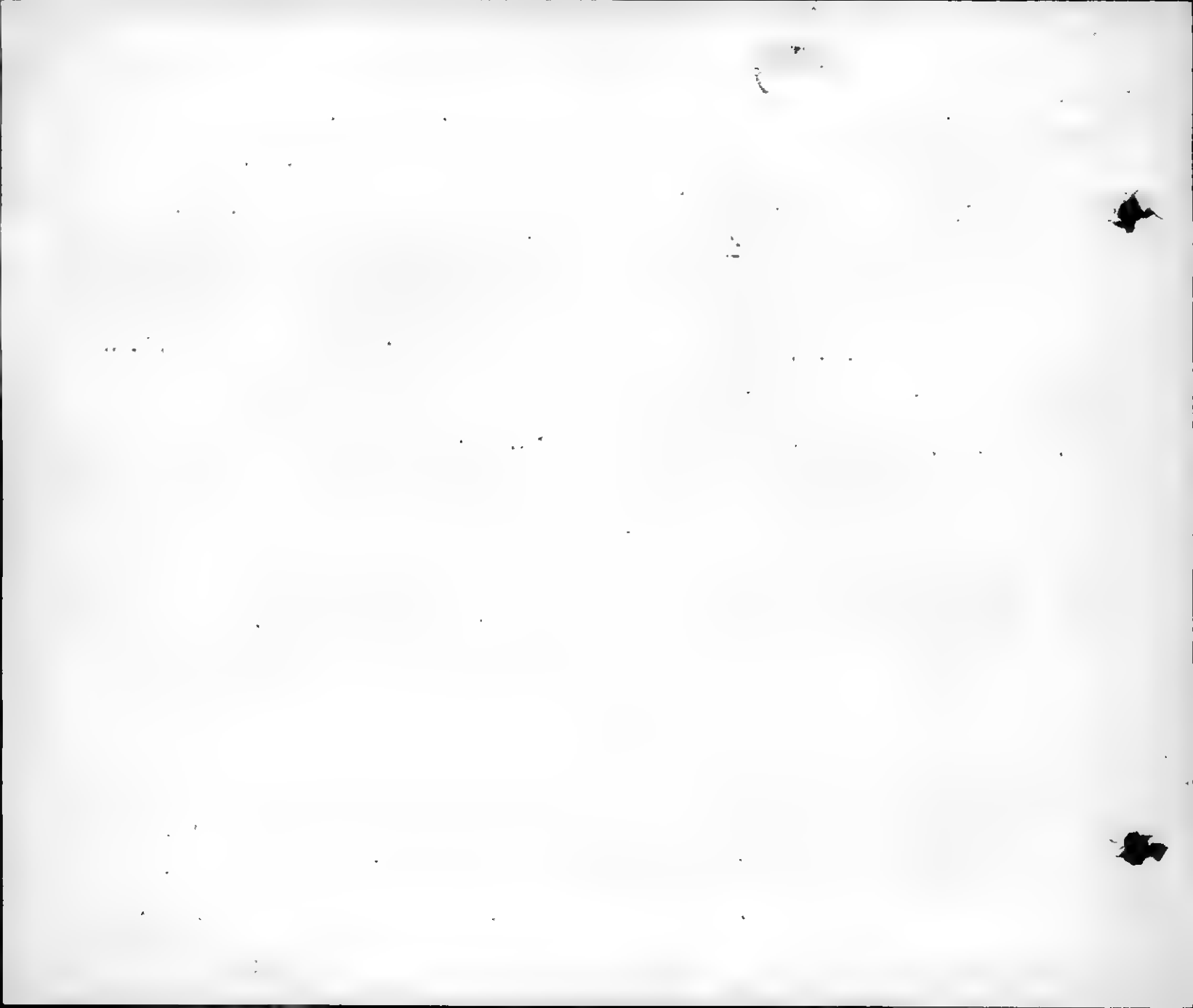
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY Washington, D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Haven Nursing Home				e. STREET ADDRESS 2700 Connecticut Ave., N.W.			
3. NAME OF DECEASED (Type or print) First Cyril Middle Lawrence Last RYALS				4. DATE OF DEATH Month December Day 17 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-23-1886	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer- G.P.O.		10b. KIND OF BUSINESS OR INDUSTRY Composition		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Lawrence Ryals				14. MOTHER'S MAIDEN NAME Judith Maria Lennan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. 1913-1919		INFORMANT Mrs. Cecilia Ryals		Address (Sister)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spontaneous Diabetic Mellitus (non-diabetic)						INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 0					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 59 to Dec 17 , 19 59 , that I last saw the deceased alive on 19 59 , and that death occurred at M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas H. Wolcott				DATE SIGNED 7401 Blaine Road NW			
PHYSICIAN'S NAME (Type) Chas H. Wolcott							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery, Arlington, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler's Sons, Inc., Washington, D.C.				24a. REC'D BY REGISTRAR DEC 21 59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

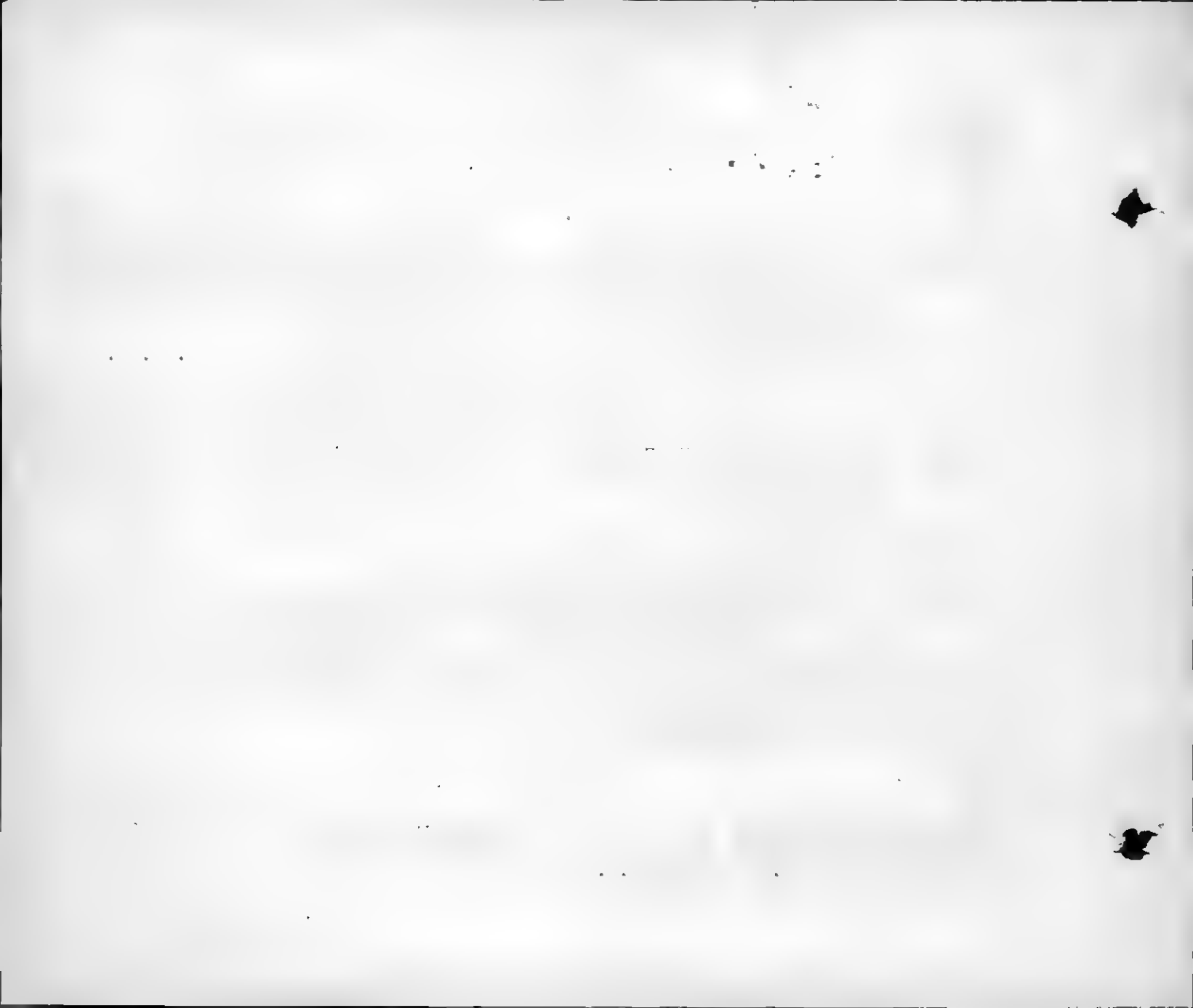
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

VS A1S (4)
15M 10/S7



1 **FOR STATE HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13975 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13941

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4602 Chase Avenue		d. STREET ADDRESS 4602 Chase Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last EDWIN JOHN SACKETT		4. DATE OF DEATH Month Day Year Dec. 5 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Month Day 2 7	11. IF UNDER 24 HRS. Hour Min 2 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Chief	
11. BIRTHPLACE (State or foreign country) New York City, N.Y.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Maurice Sackett		14. MOTHER'S MAIDEN NAME Lillian Beaver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. Yes-Unknown	
17. INFORMANT Wife		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR DEC 8 '59	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 shall be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13942

13976

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN IS <u>13 yrs</u>				d. STREET ADDRESS <u>8708 Colesville Rd Apt 203</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8708 Colesville Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Simon</u> Middle <u>Sandler</u> Last <u></u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 16 1908</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect Eng.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ben Sandler</u>				14. MOTHER'S MAIDEN NAME <u>Sannie Rosneck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Rose Ruth Sandler</u> Address <u>Itin 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>				22b. DATE THEREOF <u>12/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Graceland</u>	
22d. LOCATION (City, town, or county) (State) <u>Capitol Hill, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Flank J. Broseant</u>				24. REC'D BY REGISTRAR <u>DEC 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Baltimore Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13977

CERTIFICATE OF DEATH

Reg. Dist. No.

13943

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>3 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3216 Reservoir Road, N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret</u> First <u>(None)</u> Middle <u>Sawyer</u> Last		4. DATE OF DEATH <u>December 17</u> Month <u>1959</u> Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 16, 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nutritionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Red Cross</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Albert B. Sawyer</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Wardall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the breast</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 14, 1959</u> , to <u>December 17, 1959</u> , that I last saw the deceased alive on <u>December 17, 1959</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>12/18/59</u> NATIONAL INSTITUTES OF HEALTH <u>Bethesda 14, Maryland</u>			
ACTUAL SIGNATURE <u>Richard C. Mechanic</u>		M.D. <u>The Clinical Center</u>	
PHYSICIAN'S NAME (Type) <u>Richard C. Mechanic</u>		M.D. <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec. 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, P. G., Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley's Sons, WASH. DC.</u>		ADDRESS <u>WASH. DC.</u>	
24a. REC'D BY REGISTRAR <u>DEC 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13978

CERTIFICATE OF DEATH

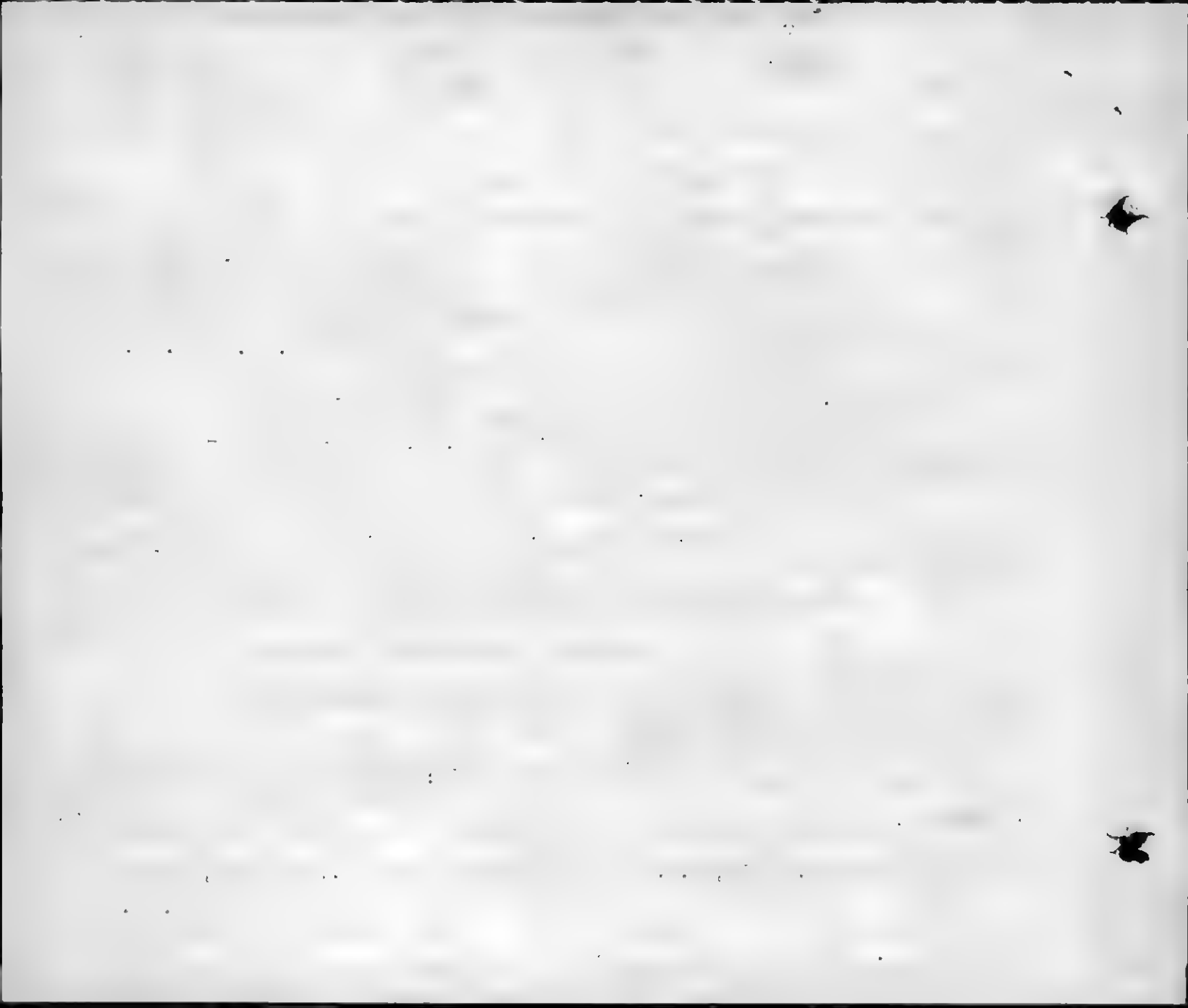
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7100 Ridgewood Road</u>			d. STREET ADDRESS <u>7100 Ridgewood Road</u>		
3. NAME OF DECEASED (Type or print) First <u>Joy</u> Middle <u>M</u> Last <u>Schmitt</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>19 59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/28/1888</u>		9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>	
13. FATHER'S NAME <u>Alfred P. Marston</u>			14. MOTHER'S MAIDEN NAME <u>Alice A. Sullivan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edwin A. Schmitt-husband-same as 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic carcinoma of left lung</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 26</u> , 19 <u>58</u> , to <u>December 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 4</u> , 19 <u>59</u> , and that death occurred at <u>11:10AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Robert G. Angle</u>		ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave., Bethesda, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Robert G. Angle, M.D.</u>		DATE SIGNED <u>12/6/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

13945

13979

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XCHEVY CHASE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RODINE NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELISE</u> Middle <u>SCHOMACKER</u> Last <u>SCHOMACKER</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 NOV 1917</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>10</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>CALIFORNIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John SAMBS</u>		14. MOTHER'S MAIDEN NAME <u>HELENE Z</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>3</u>	
17. INFORMANT <u>F. S. MOEKALL</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C. V. A.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>5-</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 1959</u> to <u>Dec 25, 1959</u> , that I last saw the deceased alive on <u>Nov 12, 1959</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Killax</u> M.D.		DATE SIGNED <u>25 Dec 59</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Killax</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>12-26-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. ...</u> ADDRESS <u>Wash. D.C.</u>		24a. RECEIVED BY REGISTRAR DATE <u>DEC 29 59</u>	24b. REGISTRAR'S SIGNATURE <u>William B. ...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 13980
 CERTIFICATE OF DEATH

13946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANDY SPRING				c. LENGTH OF STAY IN lb 8 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EUGENE Middle WILEY Last SCOTT				4. DATE OF DEATH Month DEC. Day 4 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/86	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Entomologist				10b. KIND OF BUSINESS OR INDUSTRY Dept. of Agriculture U. S. Gov't.			
11. BIRTHPLACE (State or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LEVY M. SCOTT				14. MOTHER'S MAIDEN NAME AMANDA EDMONDSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW #1				16. SOCIAL SECURITY NO. none			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy Thrombotic 260X DUE TO (b) Diabetic mellitus (c) Hypertensive cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 8 hr 5 yr 12 yr							
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)			
21. I certify that I attended the deceased from Sept 1957 to Dec 1957 , that I last saw the deceased alive on Dec 4 , 1957, and that death occurred at 7:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Md 12/4/57 DATE SIGNED ACTUAL SIGNATURE [Signature] M.D. PHYSICIAN'S NAME (Type) H. D. BONIFANT							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/7/59		22c. NAME OF CEMETERY OR CREMATORY ROCKVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				24a. REC'D BY REGISTRAR DATE DEC 8 '59			
24b. REGISTRAR'S SIGNATURE [Signature]							



13853

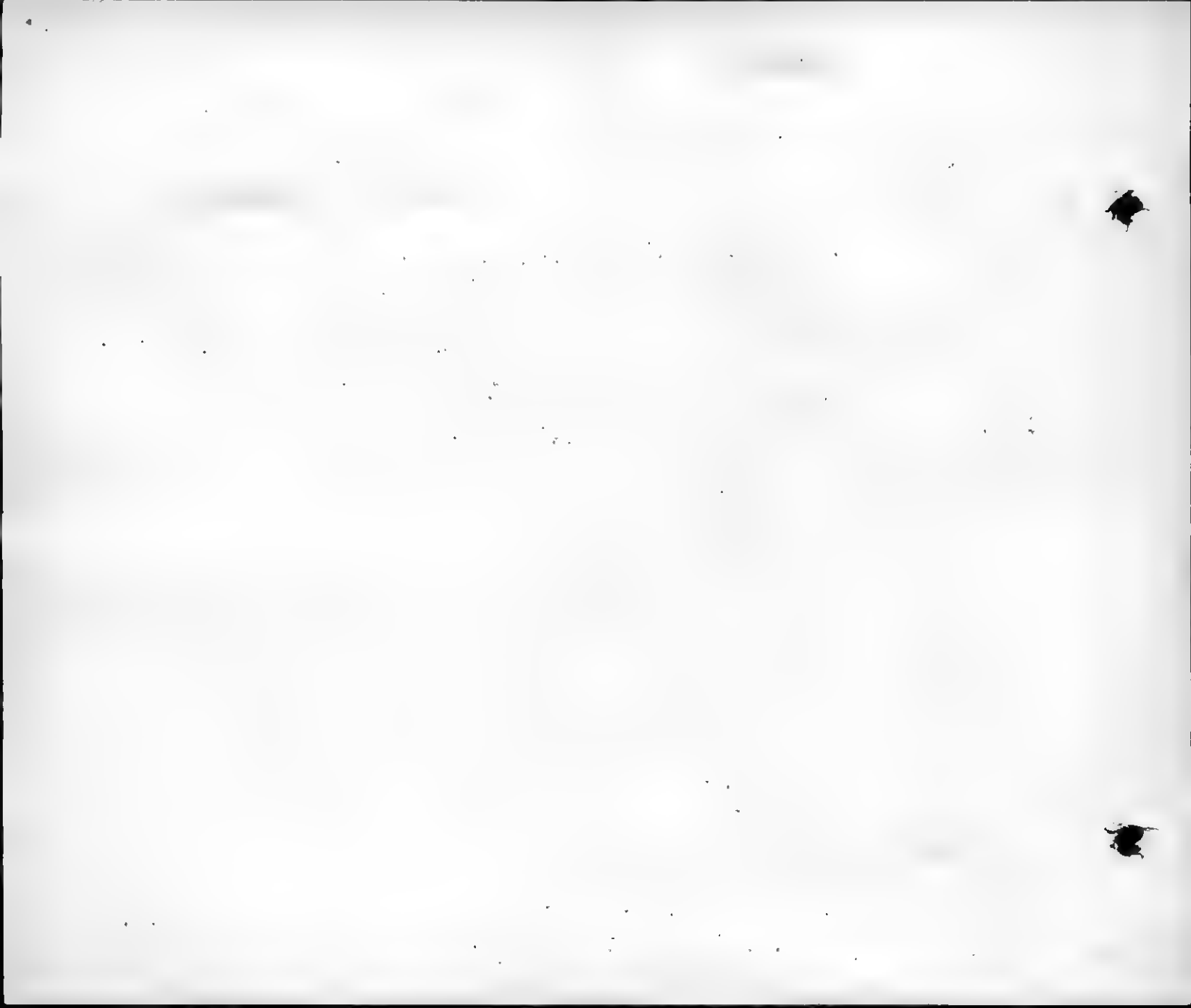
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Washington Sanitarium</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Frances</i> Middle <i>Lucine</i> Last <i>Silenspinna</i>		4. DATE OF DEATH Month <i>12</i> Day <i>2</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-5-07</i>
9. AGE (In years last birthday) <i>52 yrs.</i>		10. UNDER 1 YEAR Months <i>12</i> Days <i>2</i> Hours <i>0</i> Min. <i>0</i>	11. UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <i>Saleslady</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>W. Va.</i>	
11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Bell Ferrin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO <i>577-05-961</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>metastatic Carcinoma</i> <i>171X</i> DUE TO <i>Carcinoma of Cervix</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>171X</i> DUE TO <i>Carcinoma of Cervix</i> (c) <i>171X</i> DUE TO <i>Carcinoma of Cervix</i>		INTERVAL BETWEEN ONSET AND DEATH <i>about 12 months</i> <i>about 1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 10, 1959</i> to <i>December 2, 1959</i> , that I last saw the deceased alive on <i>December 1, 1959</i> and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Benjamin Isaacson</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>M.D. 7733 Alaska Ave. Wash. D.C. 12/2/59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/4/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill Cemetery Washington, D.C.</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co. by</i>		24a. REC'D BY REGISTRAR <i>DEC 3 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

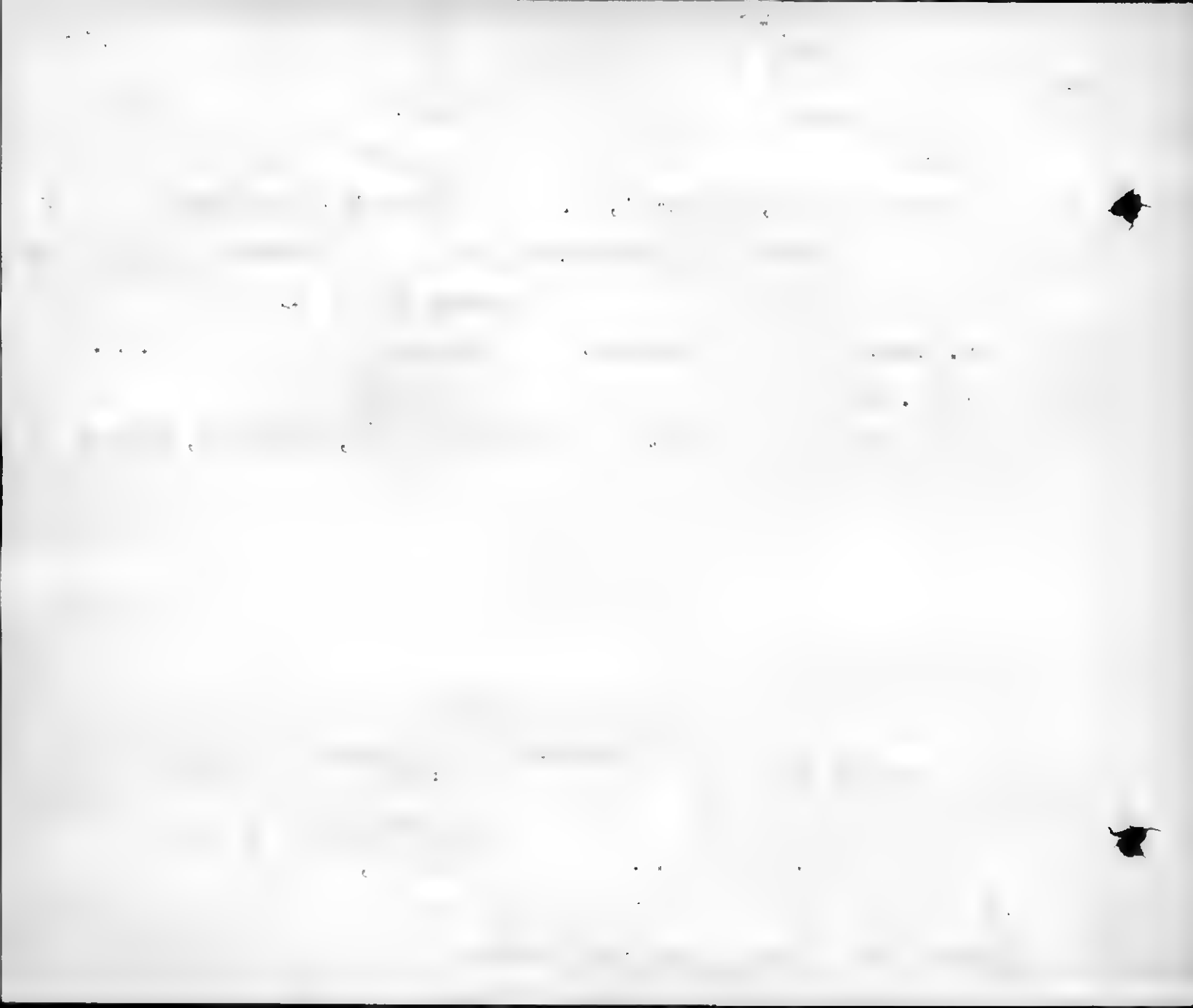


13981

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 85 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edward (No middle name) Siff		4. DATE OF DEATH Month Day Year December 18 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 January 1914
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUA. OCCUPATION (Give kind of work done during most of working life even if retired) Mgt. Analyst		10b. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Simon L. Siff	
14. MOTHER'S MAIDEN NAME Lena Levin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II	
16. SOCIAL SECURITY NO. None		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 190.9 IMMEDIATE CAUSE (a) Toxemia and Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforation of Stomach DUE TO (c) Malignant Lymphoma		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 3 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 24, 19 59 , to December 18, 19 59 , that I last saw the deceased alive on December 18, 19 59 , and that death occurred at 7:40 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/18/59 ACTUAL SIGNATURE Norman R. Gevirtz M.D. The Clinical Center PHYSICIAN'S NAME (Type) NORMAN R. GEVIRTZ, M.D. National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-59	
22c. NAME OF CEMETERY OR CREMATORY Abraham Friendship		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc 7100 Entaw Place ADDRESS 7100 Entaw Place		24a. REC'D BY REGISTRAR DEC 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2-57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13854

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13943

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in 1b <u>6 hrs. 55 min</u>		d. STREET ADDRESS <u>206 Indian Spring Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>(None)</u> Last <u>Smackey</u>		4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1882</u>
9. AGE (in years last birthday) <u>76</u>		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>20</u> Hours <u>55</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTH PLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Contusions and lacerations</u> DUE TO (c) <u>A fall down stairs</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Reported to have fallen down stairs at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-20-1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) (County) (State) <u>Silver Spring Monty Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Boschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Boschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MONTIFLORE CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD GARDENS, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Healey Funeral Home</u>		24a. REC'D BY REGISTRAR <u>4217-9th Ave</u>	
24b. REGISTRAR'S SIGNATURE <u>DATE DEC 23 '59</u>		24c. REGISTRAR'S SIGNATURE <u>DATE DEC 23 '59</u>	



13861

CERTIFICATE OF DEATH

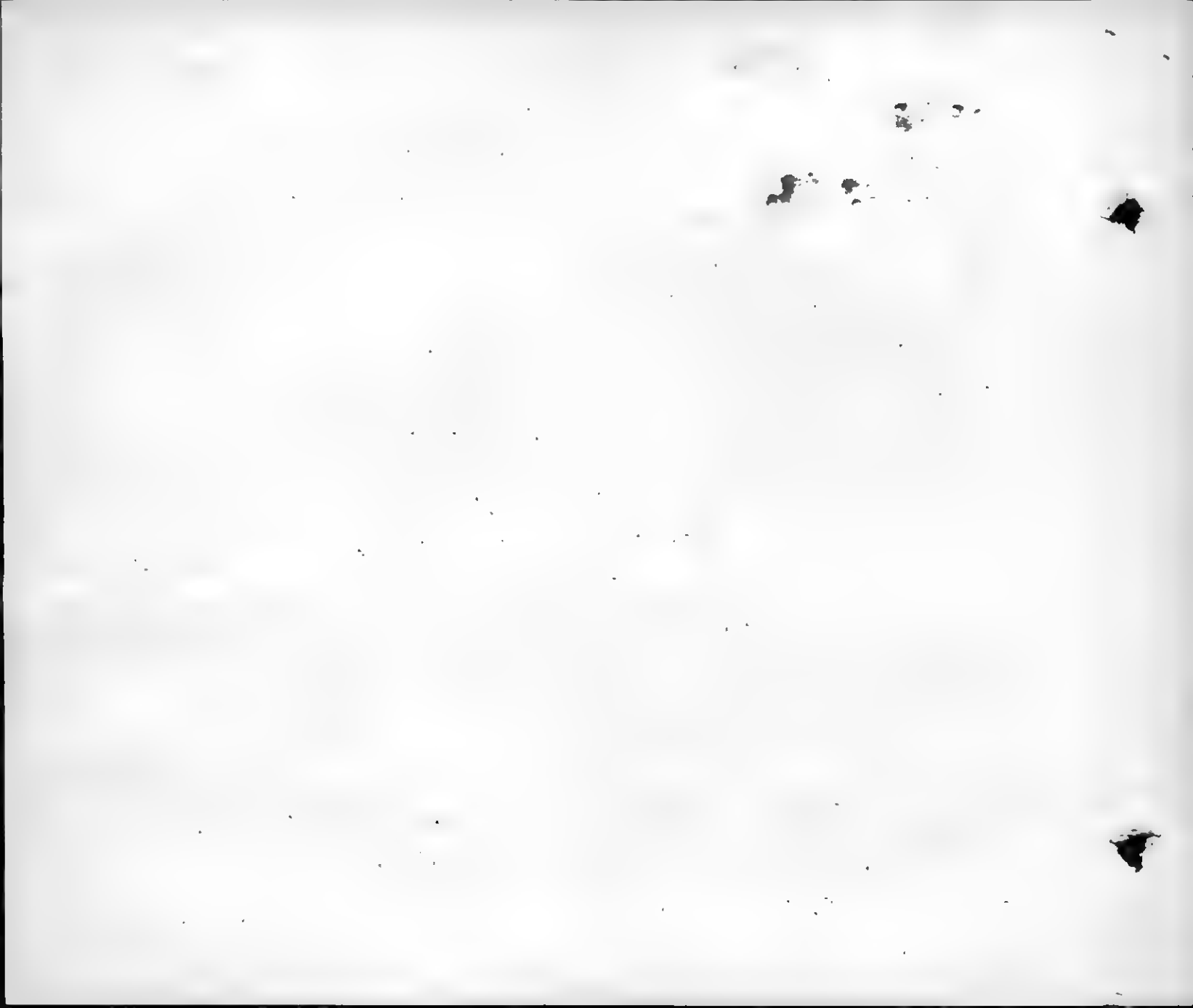
Reg. Dist. No.

13950

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 W. Argyle Street		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 2 W. Argyle Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSE E. SMITH First Middle Last		4. DATE OF DEATH Dec. 31, 1959 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/1873 9. AGE (In years last birthday) 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Charles W. Forsyth	
14. MOTHER'S MAIDEN NAME Mary F. Utterback		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO None		17. INFORMANT Address Mrs Wm. V. Robertson-Item#2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure DUE TO 002x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) for advanced atherosclerosis DUE TO tuberculosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH 1 week 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 , 19, to Dec 31 , 19 59 that I last saw the deceased alive on Dec 25 , 19 59 , and that death occurred at 7 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 110 S. Washington St. Rockville, Md. DATE SIGNED 12/31/59 ACTUAL SIGNATURE Wm. A. Linthicum M.D. PHYSICIAN'S NAME (Type) Wm. A. Linthicum Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/2/60	22c. NAME OF CEMETERY OR CREMATORY Rockville	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Tyson Wheeler Funeral Home - Rockville, Md.		24a. REC'D BY REGISTRAR DATE JAN 4 '60	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

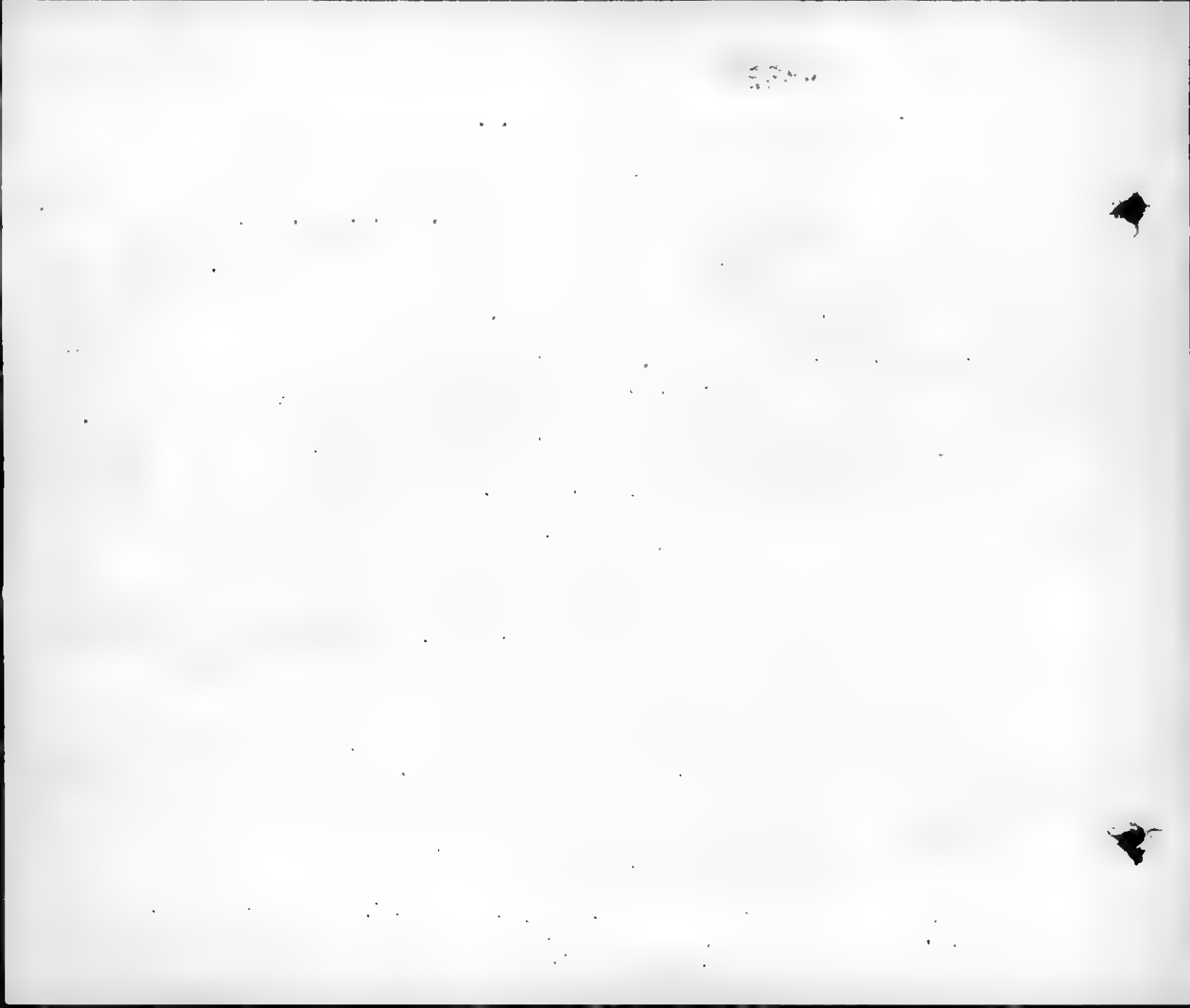
Reg. Dist. No. 13951

13982

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle F Last Smoot				4. DATE OF DEATH Month Dec. Day 31 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/11/25	
9. AGE (In years last birthday) 64 yrs.		10. KIND OF BUSINESS OR INDUSTRY Foreman - Painter		11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK P. SMOOT				14. MOTHER'S MAIDEN NAME MARY BEECHAM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Yes Army				16. SOCIAL SECURITY NO. 578-18-2023			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis heart disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 12-11-59			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sept 15-59 - Coronary infarction with occlusion							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-15 , 19 59 , to 12-31 , 19 59 that I last saw the deceased alive on 12-31 , 19 59 , and that death occurred at 9:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. Nolan M.D.				ADDRESS (Street, city or town, state) 5401 Western Ave NW			
PHYSICIAN'S NAME (Type) JAMES E. NOLAN				DATE SIGNED Washington D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.				24a. REC'D BY REGISTRAR Jan 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13983

CERTIFICATE OF DEATH

Reg. Dist. No. 13952

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>75 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Baldwin, Long Island</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1832 Longfellow Street</u> d. STREET ADDRESS <u>1832 Longfellow Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Janet</u> Middle <u>Mary</u> Last <u>Spinrad</u>		4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 16, 1912</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio-Stripper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Ralph E. Cole</u>	
14. MOTHER'S MAIDEN NAME <u>Frances Walker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, pg. or unknown) (If yes, give war or dates of service) <u>140</u>	
16. SOCIAL SECURITY NO. <u>Unascertainable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO <u>tracheobronchitis with mucous obstruction and bilateral pleural effusion</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>metastatic carcinoma from the left breast</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>months</u> <u>months</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>October 13, 1959</u> , to <u>December 27, 1959</u> , that I last saw the deceased alive on <u>December 27, 1959</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Richard C. Mechanic</u>		M.D. <u>The Clinical Center</u> <u>December 28, 1959</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD C. MECHANIC, M. D.</u>		National Institutes of Health <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>	22b. DATE THEREOF <u>12/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fresh Pond Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Queens County New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

7557 Wisconsin Ave Bethesda, Md



13984

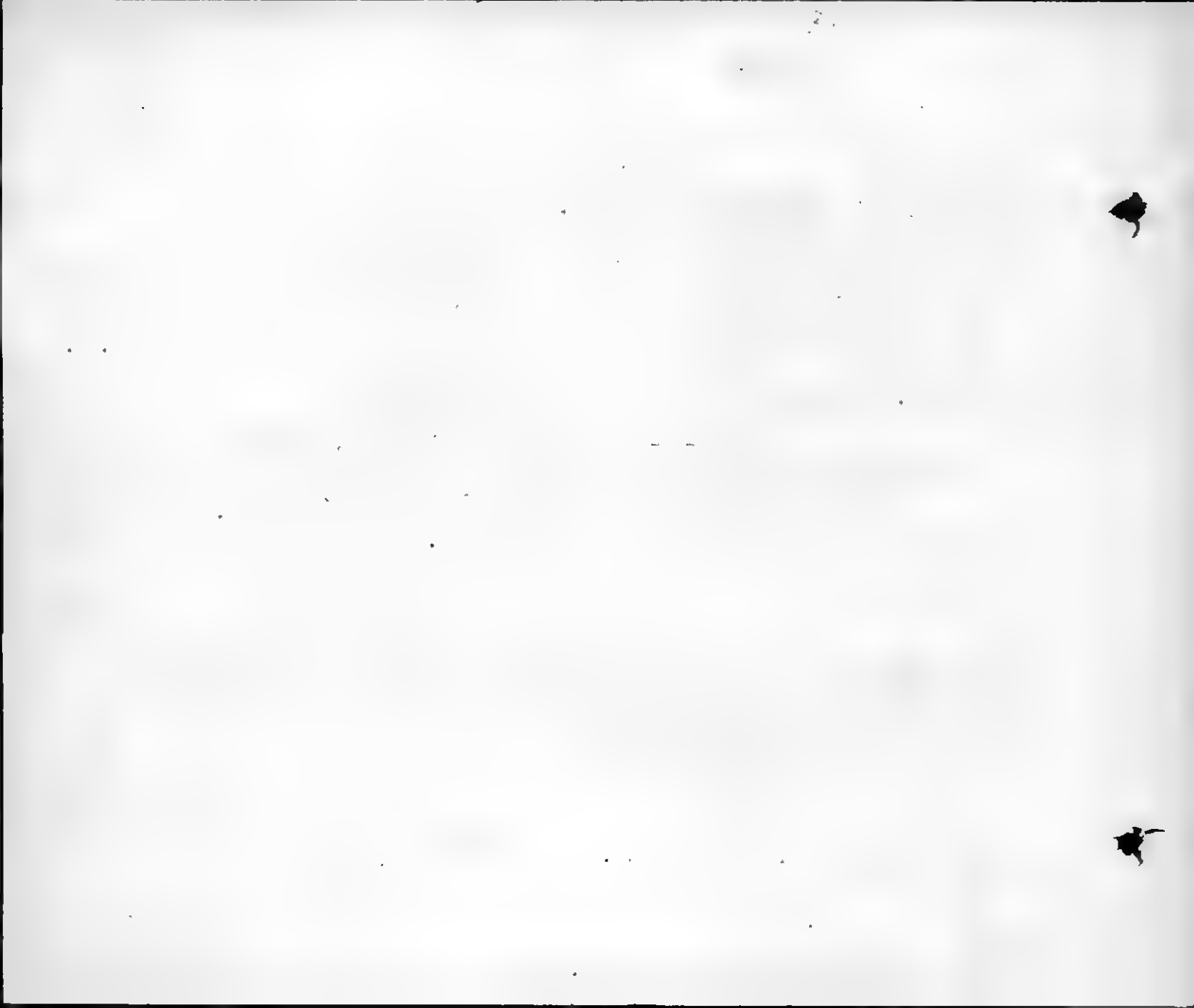
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>34</u> days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills,</u> <u>Ox</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>Box 368</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>William</u> Last <u>Sterling</u>			4. DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1959</u>		
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 22, 1896</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinery</u>	11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>George W. Sterling</u>			14. MOTHER'S MAIDEN NAME <u>Clara Lott</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-09-9303</u>	INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic Pneumonitis, Right Lung, secondary to</u> <u>204.3</u> DUE TO <u>Monilia.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Myelogenous Leukemia.</u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 Week</u> <u>2 Months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>November 27, 1959</u> to <u>December 31, 1959</u> , that I last saw the deceased alive on <u>December 31, 1959</u> , and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Harold J. Fallon</u>			ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>1/1/60</u>		
PHYSICIAN'S NAME (Type) <u>HAROLD J. FALLON, M.D.</u>			<u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 4, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>			24a. REC'D BY REGISTRAR DATE <u>JAN 5 '60</u>		
ADDRESS <u>Annapolis, Md.</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

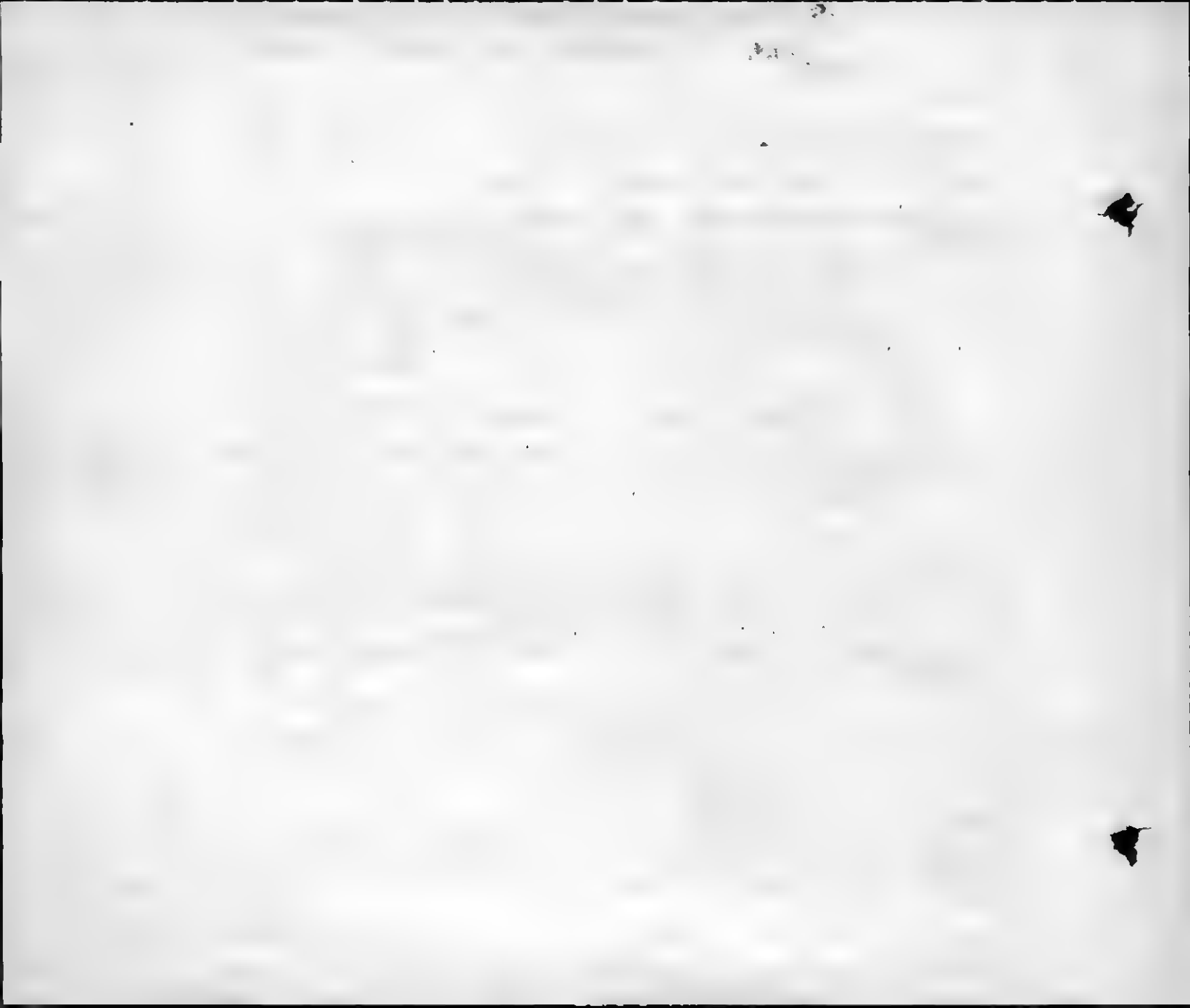
13954

13985

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				e. STREET ADDRESS 212 Brooks Ave			
3. NAME OF DECEASED (Type or print) First Arnold Middle Raymond Last Stull				4. DATE OF DEATH Month 12 Day 21 Year 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/1901	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver			10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Ulysses Stull				14. MOTHER'S MAIDEN NAME Mary J. Kaiser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mary Stull (wife)		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous coronary disease							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Bröschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Bröschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/21/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-59		22c. NAME OF CEMETERY OR CREMATORY West Hill		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kline				24a. REC'D BY REGISTRAR DEC 22 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

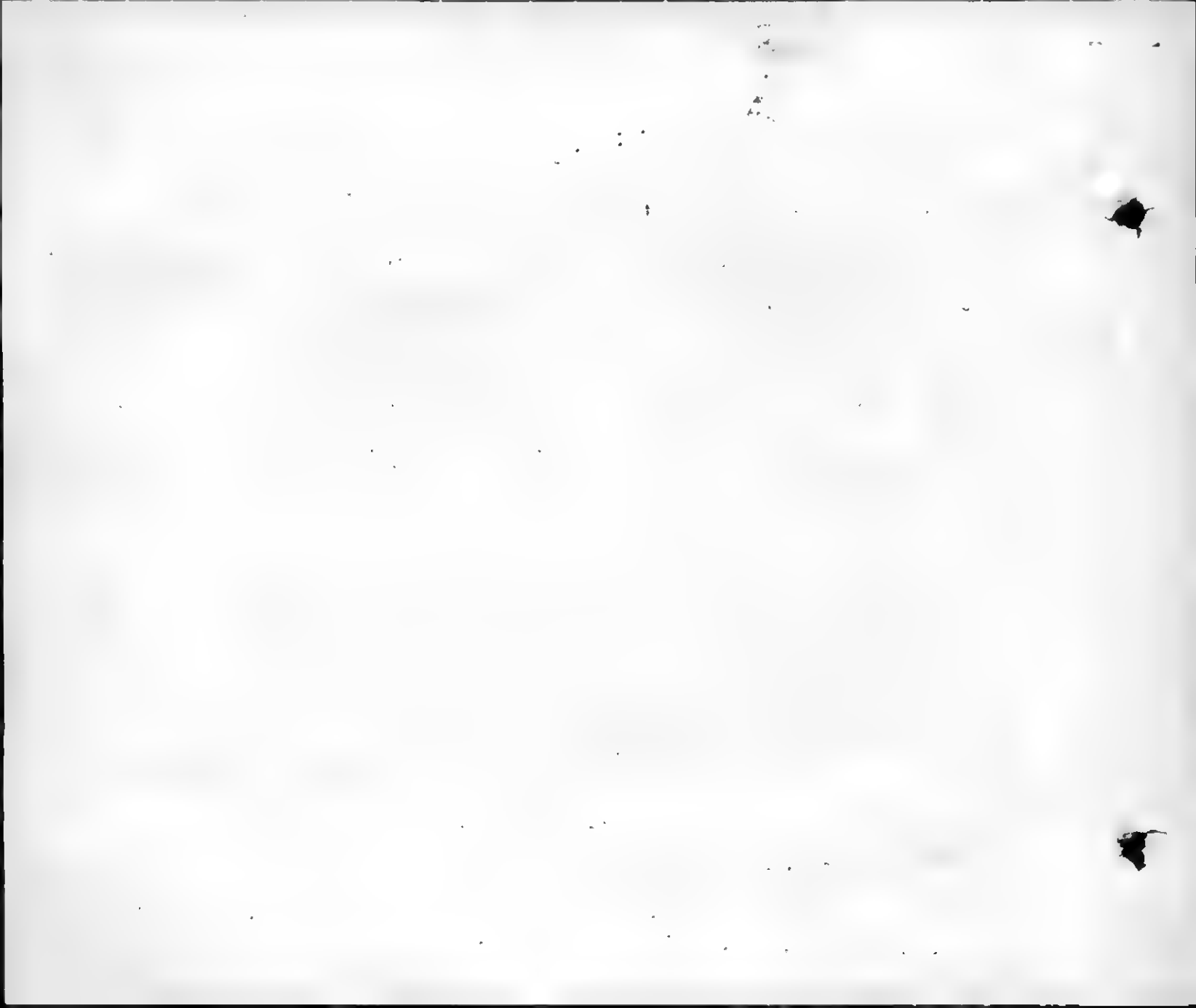


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13855
CERTIFICATE OF DEATH

Reg. Dist. No. 13955

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Gordon</u> First <u>GORDON</u> Middle <u>UK</u> Last <u>SUTTHARD, JR.</u>		4. DATE OF DEATH Month <u>JUL</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/30/59</u>
9. AGE (In years last birthday) yrs. <u>12</u>		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	IF UNDER 24 HRS. <u>12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Gordon Keith Suthard</u>	
14. MOTHER'S MAIDEN NAME <u>Isabelle Agnes LeTourneau</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mother's Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation - Pullid</u> <u>7620</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>DIFFICULT DELIVERY AT BIRTH</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 30</u> , 1959, to <u>Dec 31</u> , 1959, that I last saw the deceased alive on <u>Dec 30</u> , 1959, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1515 HIGHLAND DRIVE SILVER SPRING MD</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>George B. Spence</u> M.D.		PHYSICIAN'S NAME (Type) <u>GEORGE B. SPENCE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/2/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

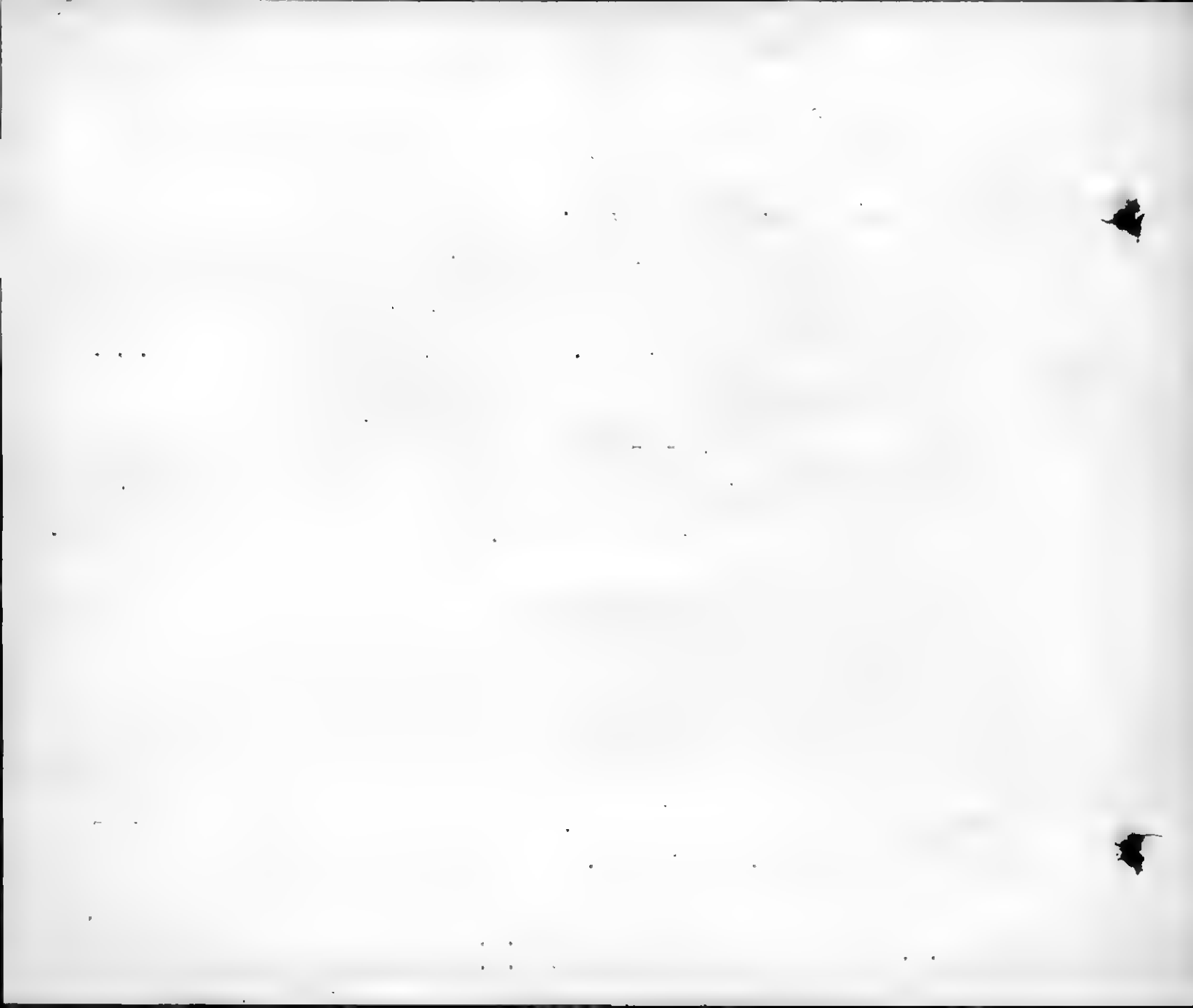


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13986
CERTIFICATE OF DEATH

Reg. Dist. No. **13956**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Orville Middle Franklin Last Taylor				4. DATE OF DEATH Month December Day 13 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 April 1921	
9. AGE (In years last birthday) 38 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman				10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME // George Taylor				14. MOTHER'S MAIDEN NAME Minnie Trader			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 330-05-5948		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Failure DUE TO (b) Epidermoid Carcinoma, Lung DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 163X INTERVAL BETWEEN ONSET AND DEATH 1 hour 18 Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from November 23, 1959 , to December 13, 1959 , that I last saw the deceased alive on December 13, 1959 , and that death occurred at 10:25 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Charles E. Mengel The Clinical Center 12-13-59 PHYSICIAN'S NAME (Type) CHARLES E. MENGEL, M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/16/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				24a. REC'D BY REGISTRAR DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13856

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admittance) b. STATE <u>Maryland</u> c. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>14 Cleveland Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Ella Sophia Terrill</u>		4. DATE OF DEATH <u>Dec 11 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-72</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>1959</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Louis Kauffman</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Blanche L. Terrill Longland - N.Y.</u>	
17. INFORMANT <u>Blanche L. Terrill Longland - N.Y.</u>		Address <u>Longland - N.Y.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - Left Hemiplegia</u>			
DUE TO <u>Senile Arteriosclerosis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO (b) <u>Senile Arteriosclerosis</u>			
DUE TO (c) <u>Senile Arteriosclerosis</u>			
PART II (OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a))			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7 Dec</u> 1959, to <u>11 Dec</u> 1959, that I last saw the deceased alive on <u>10 Dec</u> 1959, and that death occurred at <u>1:40</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. B. Queen</u>		ADDRESS (Street, city or town, state) <u>7112 Willow Ave</u> DATE SIGNED <u>11 Dec 1959</u>	
PHYSICIAN'S NAME (Type) <u>A. B. QUEEN</u>		TAkoma PARK	
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF <u>Dec-14-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stone Church Cemetery Elm Grove, West Virginia</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Hatten</u>		24a. REC'D BY REGISTRAR <u>Arthur Hatten</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur Hatten</u>	
25a. ADDRESS <u>254 Carroll St N.Y.</u>		DATE DEC 14 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1871

1871

13987

CERTIFICATE OF DEATH

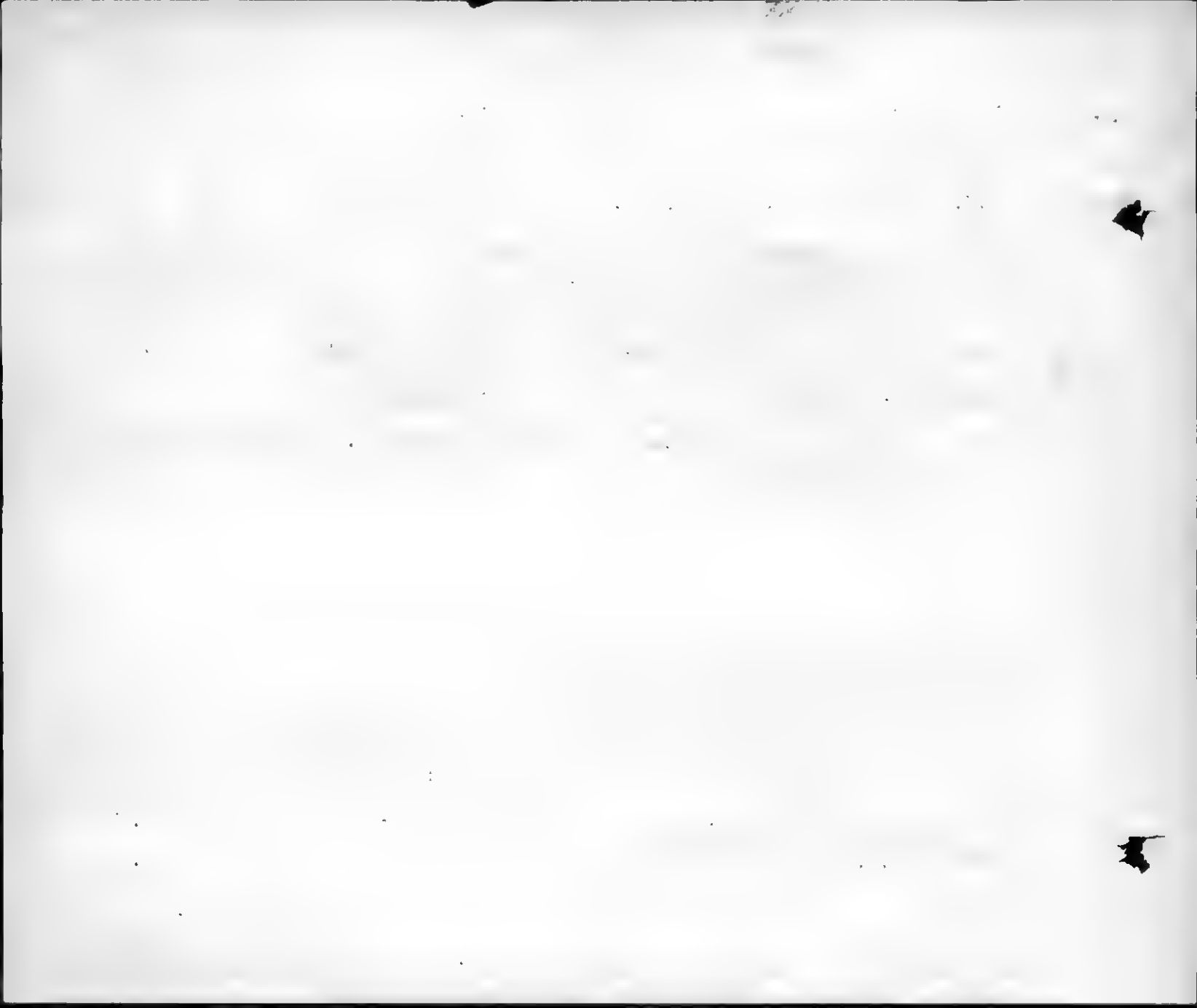
Reg. Dist. No. 215

13958

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 37 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward D THIEBAUD				4. DATE OF DEATH Month Day Year December 20 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-7-57	
9. AGE (In years lost birthday) yrs 2		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
13. FATHER'S NAME Charles J. THIEBAUD				14. MOTHER'S MAIDEN NAME Herta WARTGEG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Address (Father) Charles J. Thiebaud Same as #2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NEUROBLASTOMA 1954 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 13 November, 1959 , to 20 December 1959 , that I last saw the deceased alive on 20 December, 1959 , and that death occurred at 11:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Fred W. Grello M.D. U.S. Naval Hospital, Bethesda Md. 12-21-59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) F.W. GRELLIO LT MC USN U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-59		22c. NAME OF CEMETERY OR CREMATORY National Hampton Cemetery		22d. LOCATION (City, town, or county) (State) Hampton Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R. Hayden Smith 245 Armistead Ave. Hampton Va.				24a. REC'D BY REGISTRAR DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Fraws	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13988 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13953

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney, Md.</u>		c. LENGTH OF STAY IN 1b <u>7 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Co. Gen. Hosp.</u>		e. STREET ADDRESS <u>Chandlee Mill Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Malchia Thomas</u>		4. DATE OF DEATH Month Day Year <u>12 17 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/14</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Clifton Edward Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mamie Simpson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital records</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1st, 2nd and 3rd degree burns involving head, trunk and extremities.</u> DUE TO (c) <u>burning of house.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burning of home.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>9-20 12 16 19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Sandy Spring, Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart,</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

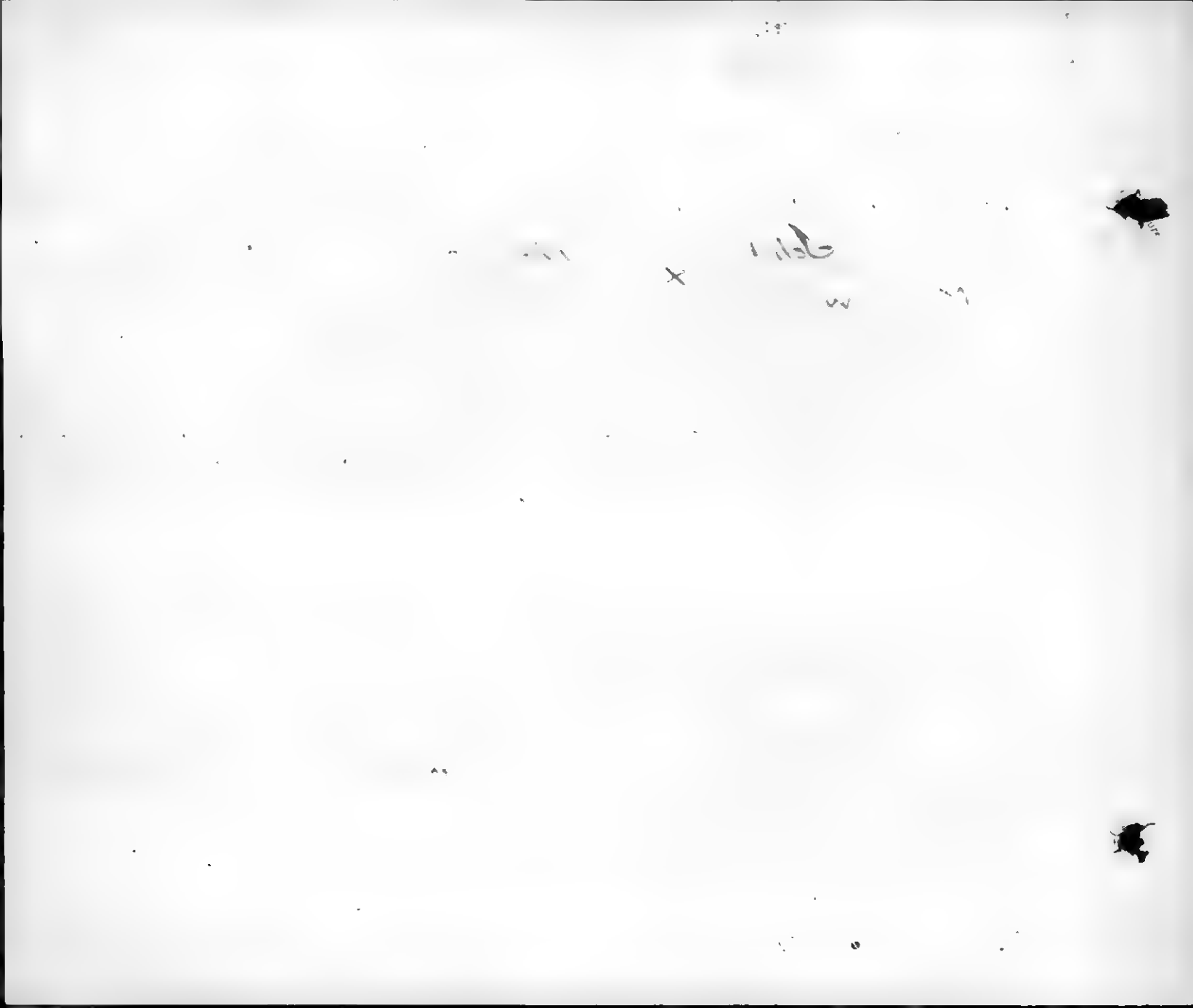
13960

13989

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
f. STREET ADDRESS <u>4919 SEDGWICK ST., N.W.</u>				g. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John W Thompson</u>				4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1959</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/1892</u>		9 AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	IF UNDER 24 HRS Hours <u>4</u> Min <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOV'T.</u>		11. BIRTHPLACE (State or foreign country) <u>WASH., D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROSS THOMPSON</u>				14. MOTHER'S MAIDEN NAME <u>WENA DeBRULER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES</u>		16 SOCIAL SECURITY NO. <u>577-03-1023</u>		INFORMANT Address <u>IMOGEN THOMPSON, 4919 SEDGWICK ST., N.W. WASHINGTON, D. C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, right lung.</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>36 hours.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. anemia 2. congestive heart failure. 3. Parkinson's disease.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> , 1958, to <u>4 December</u> , 1959, that I last saw the deceased alive on <u>3 December</u> , 1959, and that death occurred at <u>10:08 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>929 Potomac Avenue, Silver Spring, Maryland</u> DATE SIGNED <u>4 Dec., 1959.</u>							
ACTUAL SIGNATURE <u>Seruch T. Kimble</u> M.D.				PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12/8/59</u>		<u>A LINGTON NAT'L CEM.</u>		<u>FORT MYER, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hewitt</u> ADDRESS <u>1756 PA. AVE., N.W. DC</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



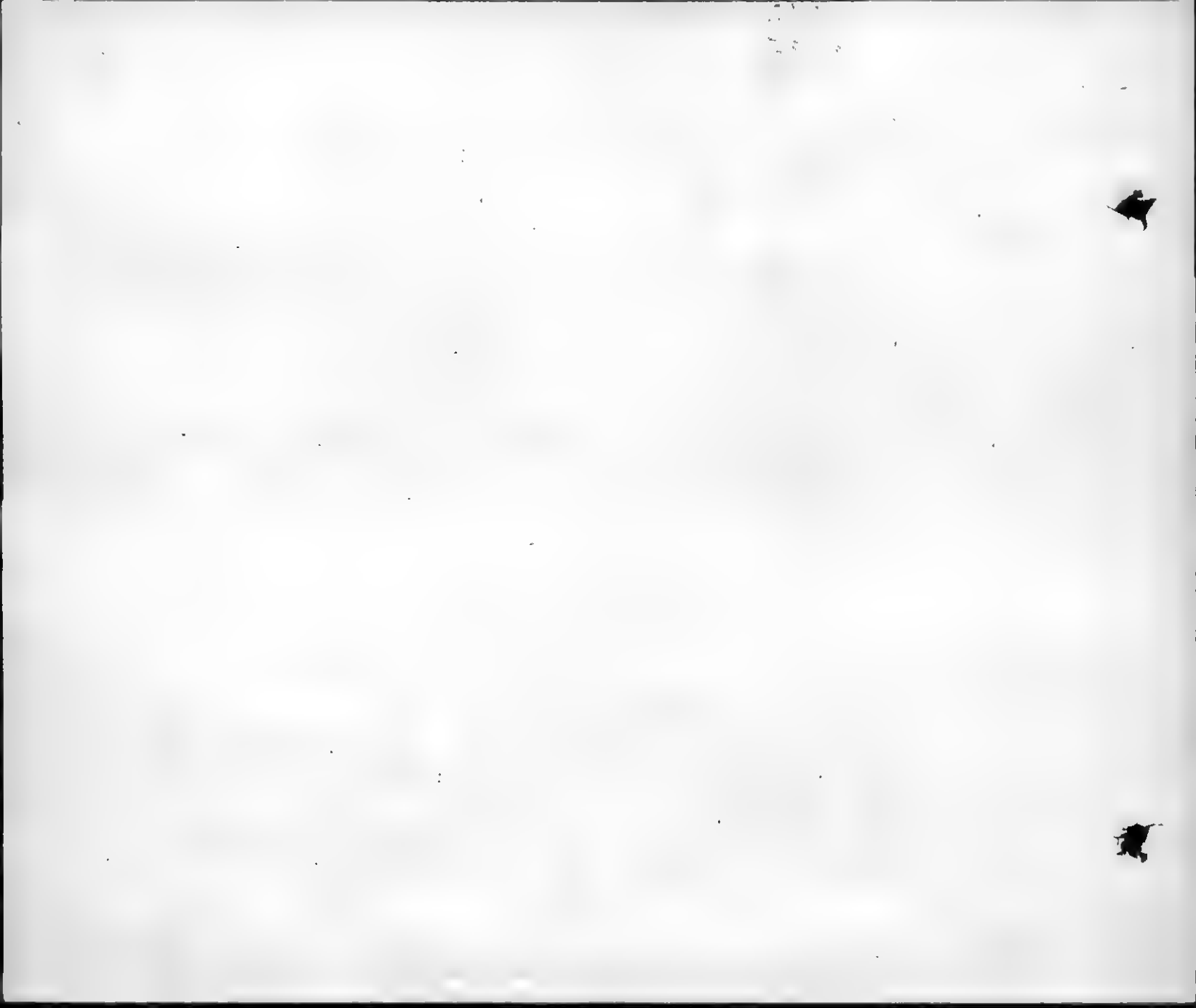
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 13990 CERTIFICATE OF DEATH

13961

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital NNMC		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rose Yearly THOMPSON		4. DATE OF DEATH December 12 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 30 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Yearly		14. MOTHER'S MAIDEN NAME Alice CRABTREE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
INFORMANT (Son) Robert THOMPSON		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 154X Adenocarcinoma Rectum & metastases DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 November, 1959 , to 12 December, 1959 , that I last saw the deceased alive on 12 December, 1959 , and that death occurred at 4:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE B. C. Johnson M.D.			
PHYSICIAN'S NAME (Type) B.C. Johnson LCDR MC USN U.S. NAVAL HOSPITAL Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-15-59	22c. NAME OF CEMETERY OR CREMATORY Cecil Cemetery	22d. LOCATION (City, town or county) (State) Vienna, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home Rockville, Md.		24a. REC'D BY REGISTRAR DEC 16 '59	24b. REGISTRAR'S SIGNATURE O. L. S. Knecht

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13962

13991

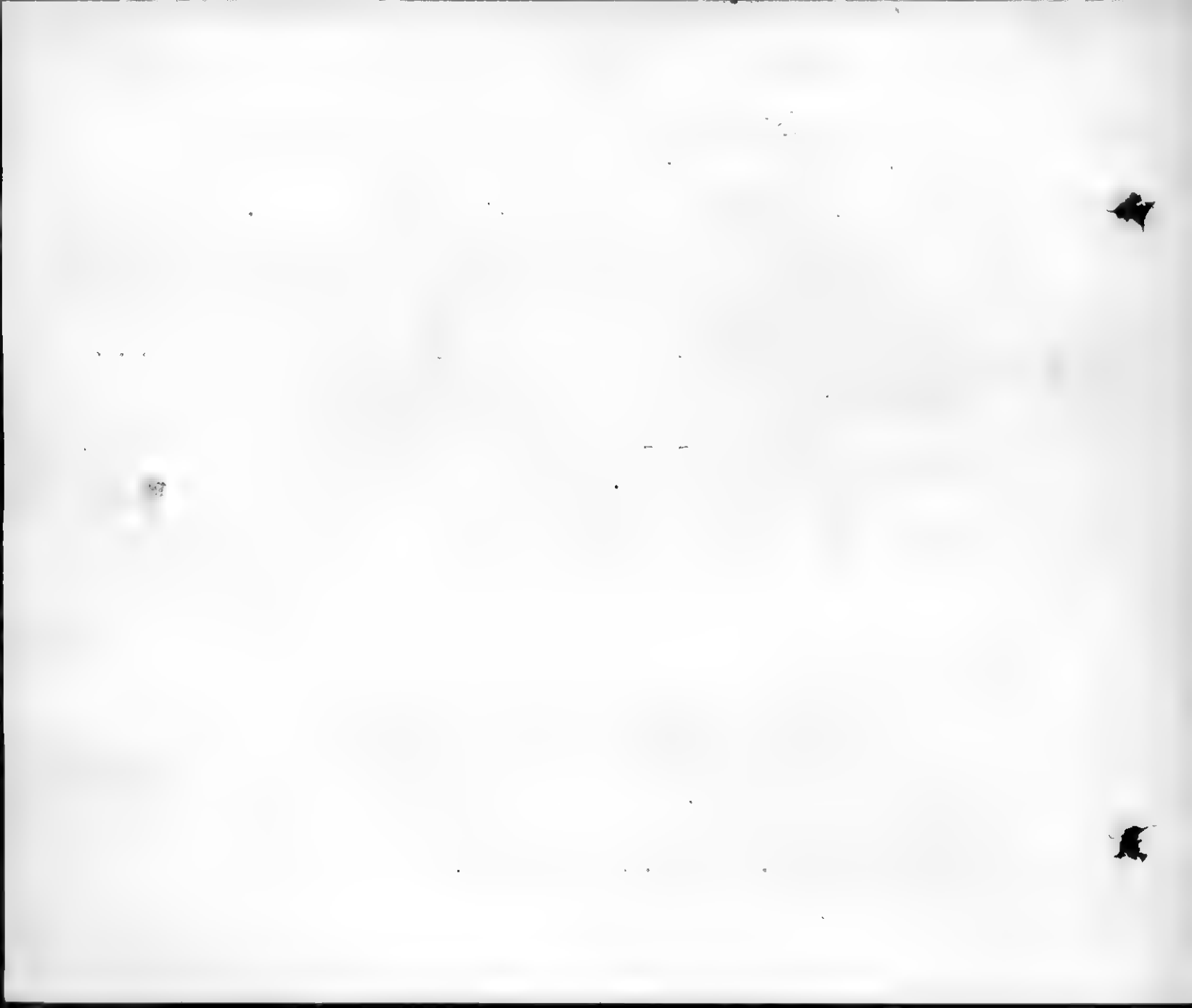
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>41</u> days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>(None)</u> Last <u>Trossbach</u>				4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>19 59</u>			
5 SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 July 1890</u>	
9 AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Phillip Trossbach</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Romeise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>218-14-3427</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriolar Nephrosclerosis</u> DUE TO (c) <u>Carcinoma of the Rectum</u>				INTERVAL BETWEEN ONSET AND DEATH <u>73</u> days <u>?</u> years <u>2</u> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic Carcinoma in Liver, Myocardial Hypertrophy, Atherosclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Generalized</u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>November 13, 1959</u> to <u>December 24, 1959</u> that I last saw the deceased alive on <u>December 24, 1959</u> and that death occurred at <u>11:05 AM</u> , from the causes and on the date stated above							
ADDRESS (Street, city or town, state) <u>The Clinical Center</u>				DATE SIGNED <u>12/25/59</u>			
ACTUAL SIGNATURE <u>Alan B. Retik</u>							
PHYSICIAN'S NAME (Type) <u>ALAN B. RETIK, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u>		22d. LOCATION (City, town, or county) (State) <u>Ridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. L. S. F. F. F.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13963

13992

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 21 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9010 Seneca Lane				d. STREET ADDRESS 9010 Seneca Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle D Last Urry				4. DATE OF DEATH Month December Day 16 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1905		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 15 Days 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scientist		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Albert Urry				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Greta Urry-wife-same as 2d Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 15 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John G. Ball</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		16 Dec 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE DEC 21 '59	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



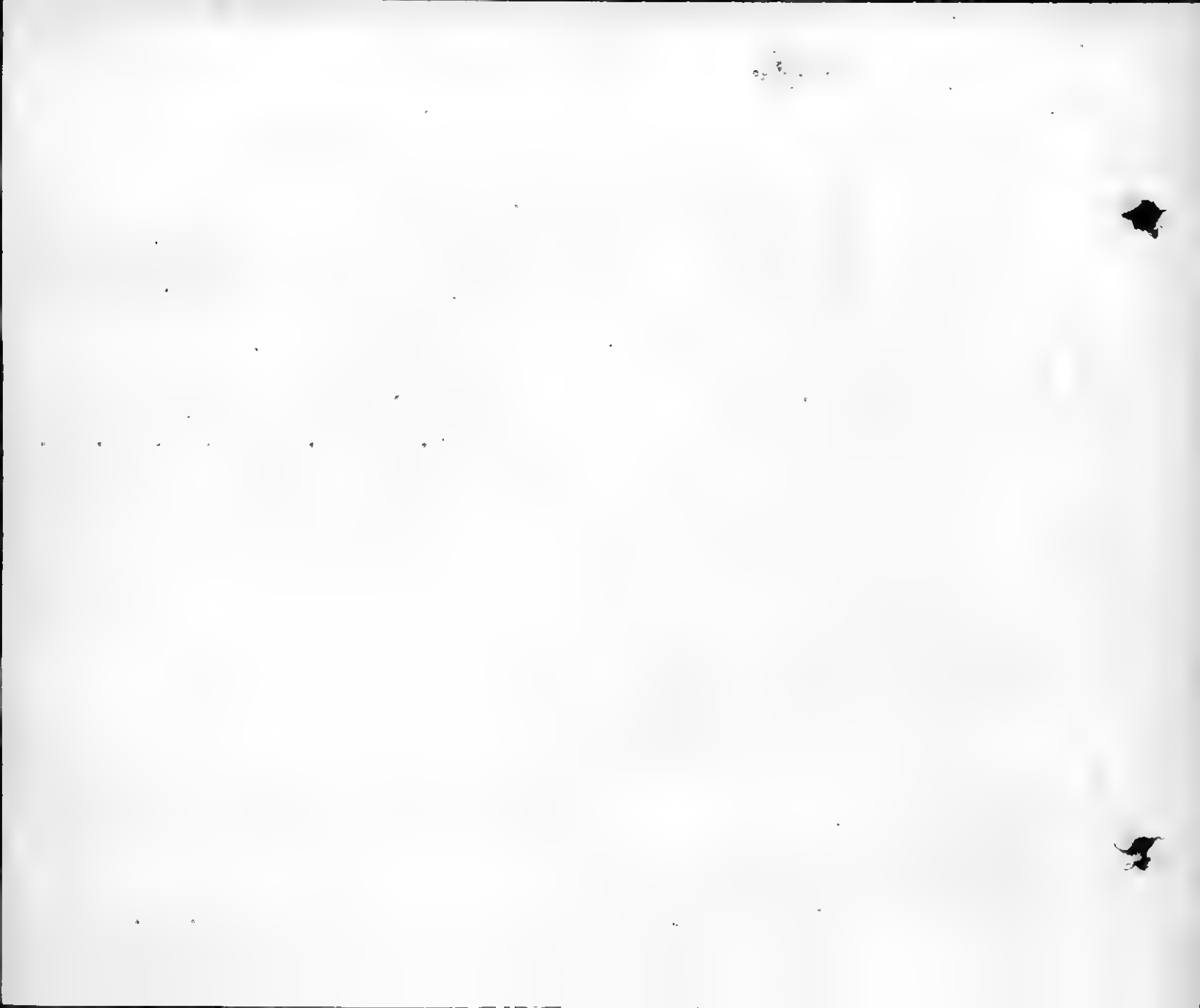
CERTIFICATE OF DEATH

Reg. Dist. No. 13964

13993

1 PLACE OF DEATH a COUNTY <u>Monoc</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE <u>MD</u> b COUNTY <u>CLL</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ciney</u>		c LENGTH OF STAY IN 1b <u>7Hrs</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Monoc, Co, General Hospital</u>		d STREET ADDRESS <u>111 Walker Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>Murray</u> Last <u>Walker</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>17</u> Year <u>1959</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct 19-1880</u>
9 AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retail grocery</u>	11 BIRTHPLACE (State or foreign country) <u>Illinois, Ill.</u>
12 CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13 FATHER'S NAME <u>George L. Walker</u>		14 MOTHER'S MAIDEN NAME <u>Lilla S. Miles</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16 SOCIAL SECURITY NO <u>INFORMANT</u>	
17 Address <u>111 Walker Ave</u> <u>Minnie B. Walker. Gaithersburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage, Retroperitoneal,</u> <u>451x</u> DUE TO <u>due to rupture abdominal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aorta.</u> DUE TO <u>Atherosclerosis</u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u> <u>Unknown</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>59</u> to <u>Dec. 17</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Dec. 18</u> , 19 <u>59</u> , and that death occurred at <u>2 1/2</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack Schumacher</u>		ADDRESS (Street, city or town, state) <u>105 Russell Ave., 12-18-</u>	
PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>		DATE SIGNED <u>12-18-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>11-18</u>	<u>12-18-59</u>	<u>Forest Oak</u>	<u>Gaithersburg, Md.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Gathens</u>		24a REC'D BY REGISTRAR DATE <u>DEC 21 '59</u>	24b REGISTRAR'S SIGNATURE <u>Arthur E. Gathens</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

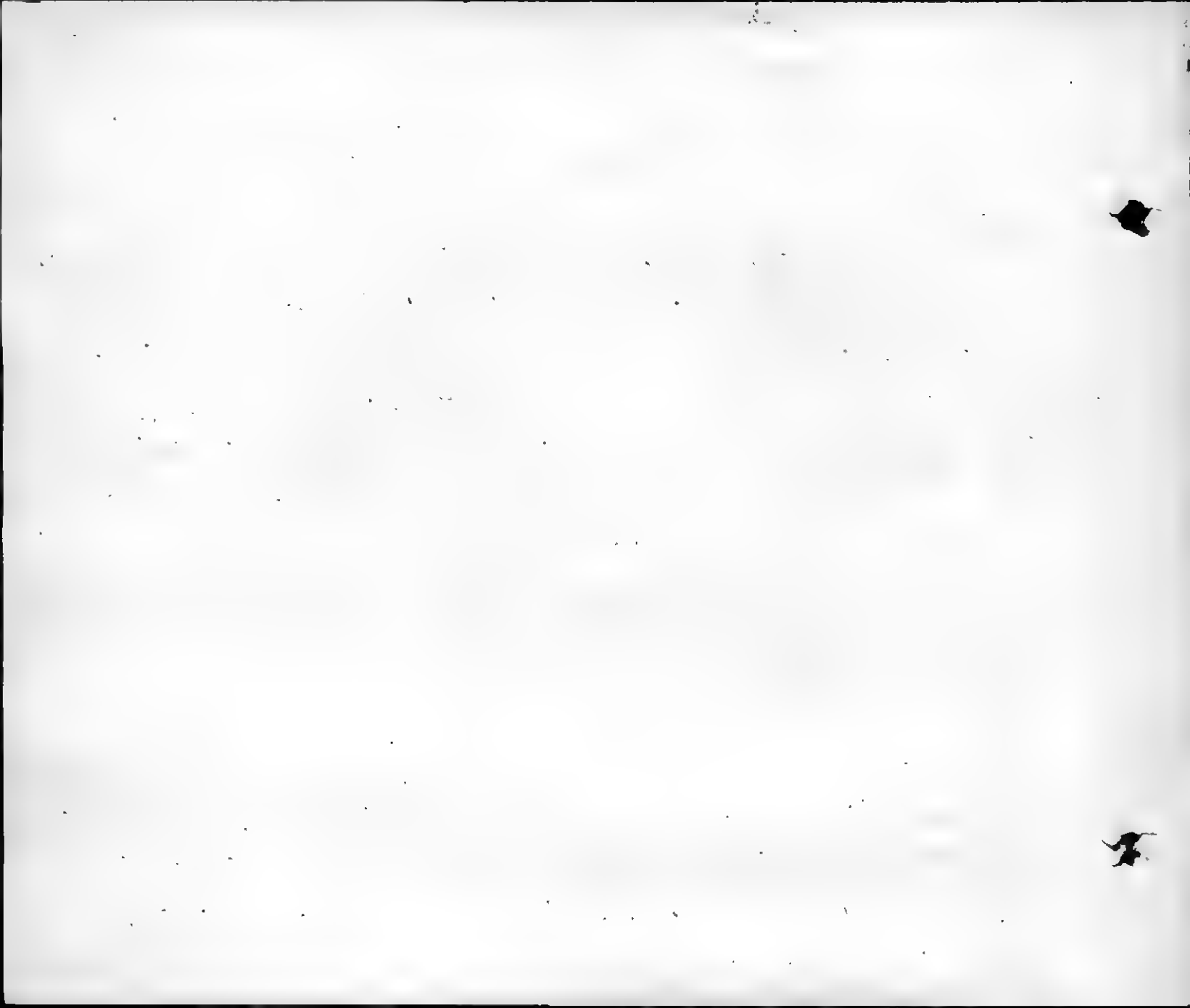
CERTIFICATE OF DEATH

Reg. Dist. No.

13965

13994

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 days</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EOLIA</u> Middle <u>Ann</u> Last <u>Ward</u>		4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Huthum</u>		14. MOTHER'S MAIDEN NAME <u>Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Paul B. Wardell, 356 Granther</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombus</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1, 1958</u> , to <u>Dec 3, 1959</u> , that I last saw the deceased alive on <u>Dec 3, 1959</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.S. Murphy</u> M.D.		ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>Dec 3, 1959</u>	
PHYSICIAN'S NAME (Type) <u>W.S. MURPHY</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>12/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u> ADDRESS <u>Mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>	



13995

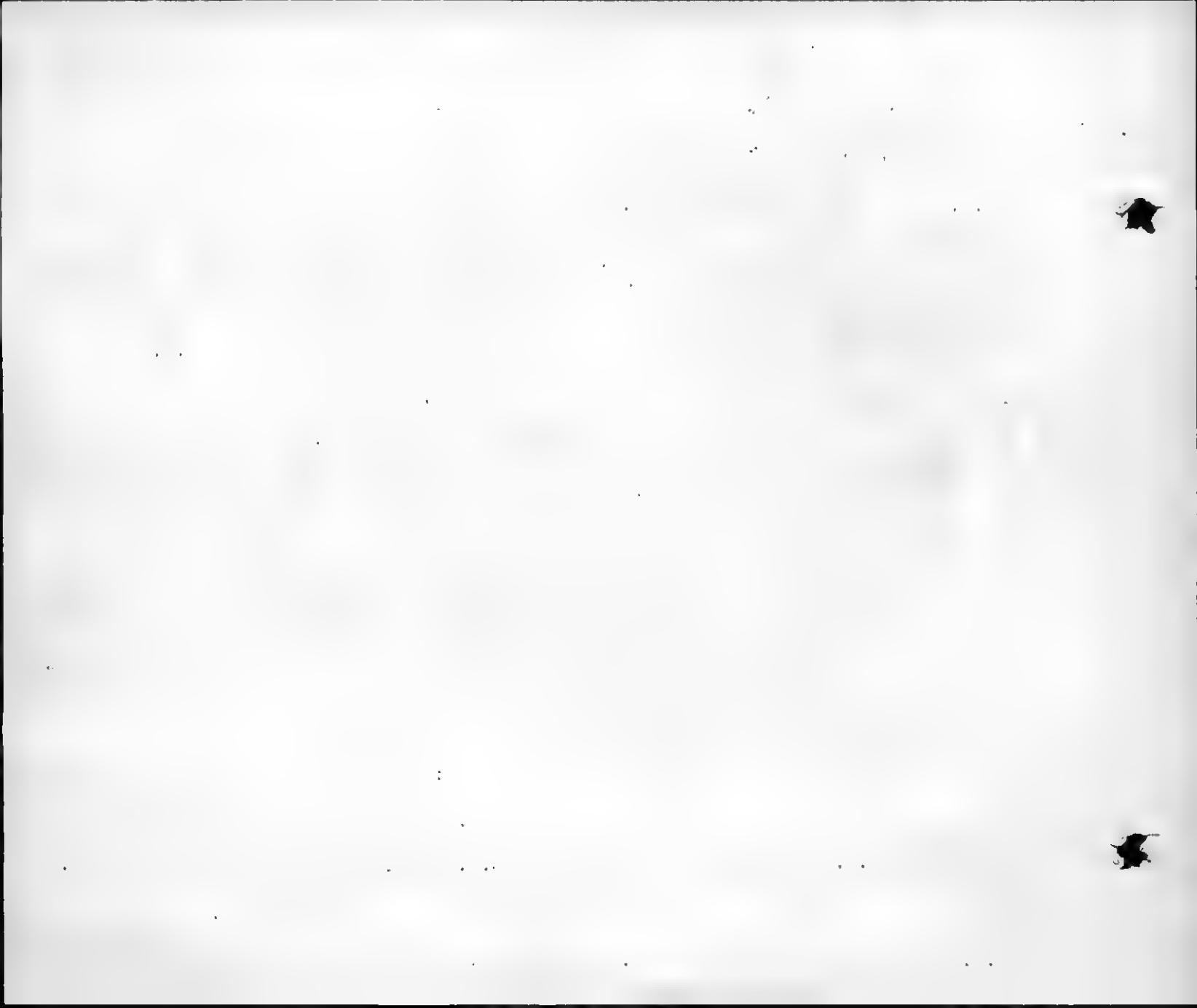
CERTIFICATE OF DEATH

Reg. Dist. No 215

1. PLACE OF DEATH COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) STATE Maryland COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		d. STREET ADDRESS Cobb Island	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Wanda Deane WARREN		4. DATE OF DEATH Month Day Year December 4 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-16
9. AGE (In years lost birthday) 43		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Horace Edwards		14. MOTHER'S MAIDEN NAME Zell M. JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT (Husband) James L. Warren	
17. ADDRESS Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction + electrolyte imbalance 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lacunar's cirrhosis DUE TO (c) 1 year INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 November , 1959, to 4 December , 1959, that I last saw the deceased alive on 4 December , 1959, and that death occurred at 6:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md DATE SIGNED 12-4-59 ACTUAL SIGNATURE R. G. Muth PHYSICIAN'S NAME (Type) R.G. MUTH LT MC USN U.S. Naval Hospital, NNMC, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-8-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumpfrey ADDRESS 7551 Wisconsin Ave. Bethesda Md.		24a. REC'D BY REGISTRAR DATE DEC 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13996

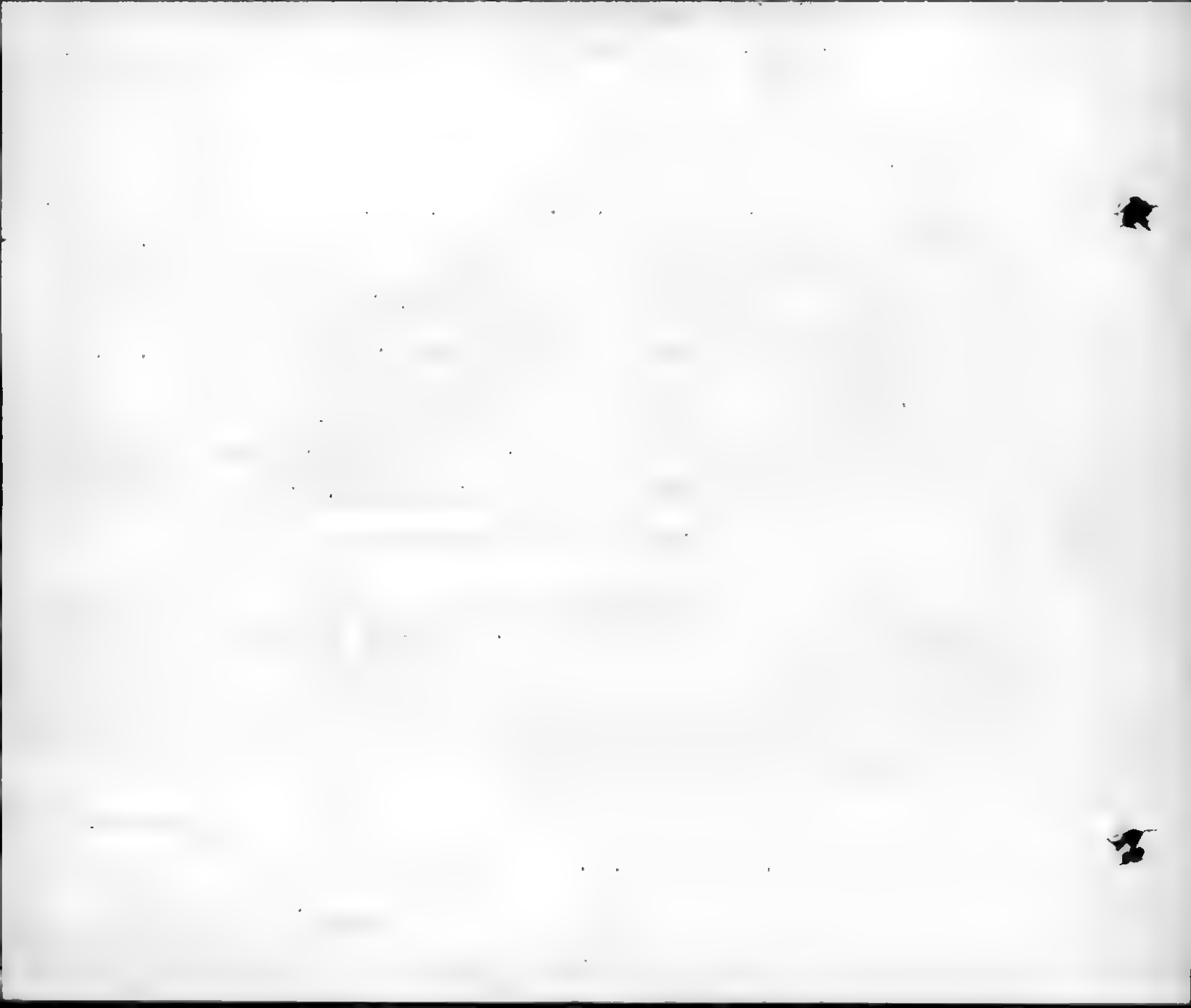
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY King George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) King George	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS Route #2, Box 68	
3. NAME OF DECEASED (Type or print) First Henry Middle George Last Wegner		4. DATE OF DEATH Month December Day 28 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 January 1897
9. AGE (In years lost birthday) 62 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public works inspector		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul L. Wegner		14. MOTHER'S MAIDEN NAME Matilda Roesky	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. UNASCERTAINABLE	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line—far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) thrombosis of thoracic and abdominal aorta 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized severe arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malignant lymphoma: skin, lymph nodes, spleen, kidney, liver			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 19, 1959 , to December 28, 1959 , that I last saw the deceased alive on December 28, 1959 , and that death occurred at 5:30 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland DATE SIGNED December 28, 1959			
ACTUAL SIGNATURE Richard C. Mechanic M.D.		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) RICHARD C. MECHANIC, M. D.			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/1959	22c. NAME OF CEMETERY OR CREMATORY Oakland	22d. LOCATION (City, town, or county) (State) Owens, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Nash & Slaw by [Signature]		ADDRESS Ninde, Virginia	24a. REC'D BY REGISTRAR DEC 31 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

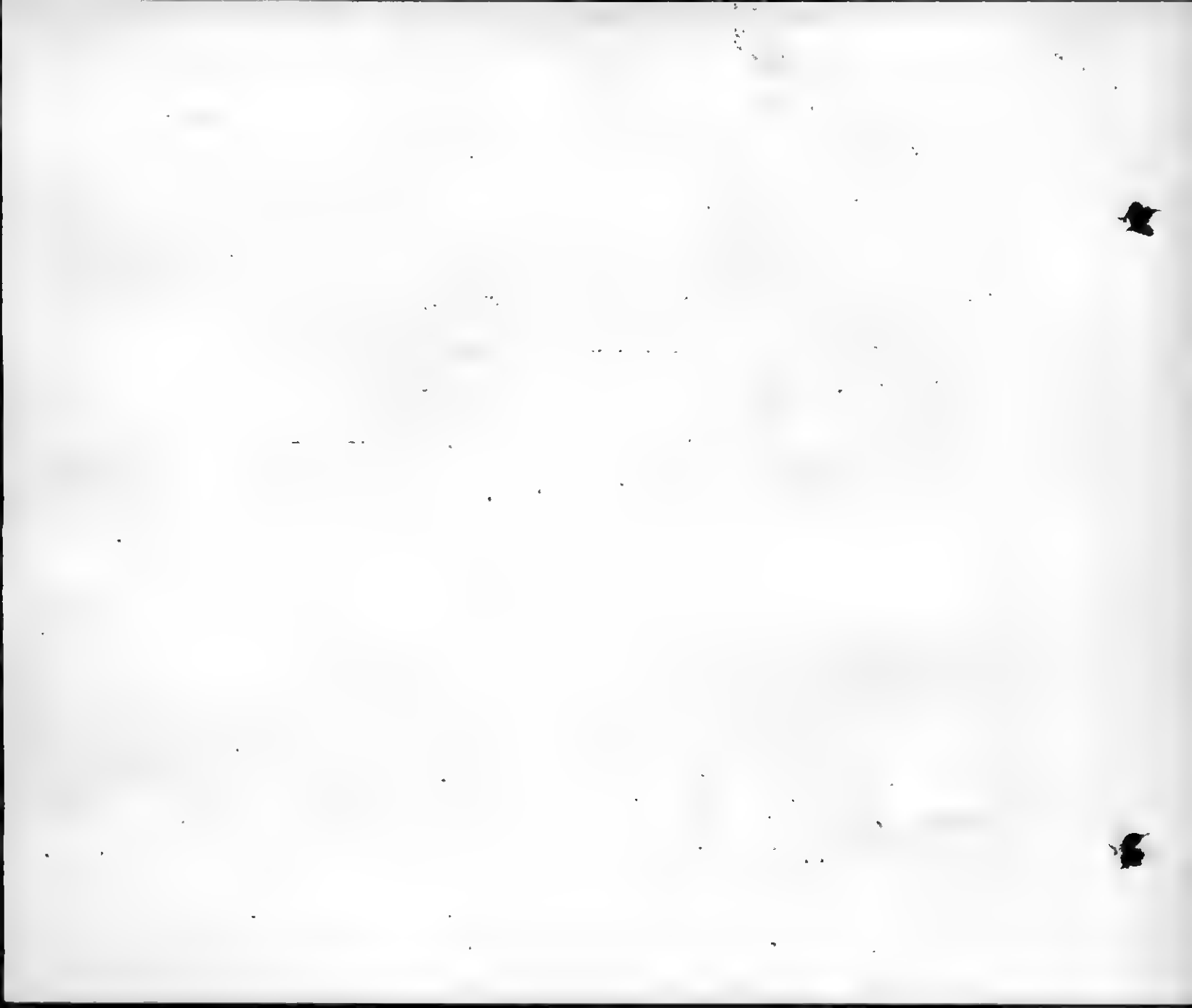
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13997

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 3 years		d. STREET ADDRESS 7611 Whittier Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7611 Whittier Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IDA Middle BELLE Last WELLS		4. DATE OF DEATH Month Dec. Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1872
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 6 Days 9	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Charles Storrin	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO None		INFORMANT Robert A. Wells-son-same as 2d Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS, LEFT 33 x x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) ARTERIOSCLEROSIS, GENERAL DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 14 HRS. 5 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JUNE , 19 58 , to DEC. , 30, 19 59 , that I last saw the deceased alive on DEC. , 30, 19 59 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo M. Curtis M.D. EXX		ADDRESS (Street, city or town, state) 8218 Wisconsin Ave. DATE SIGNED	
PHYSICIAN'S NAME (Type) LEO M. CURTIS		Bethesda, Maryland 12-31-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/2/60	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. RECEIVED BY REGISTRAR JAN 4 60 DATE	24b. REGISTRAR'S SIGNATURE Arthur L. Huns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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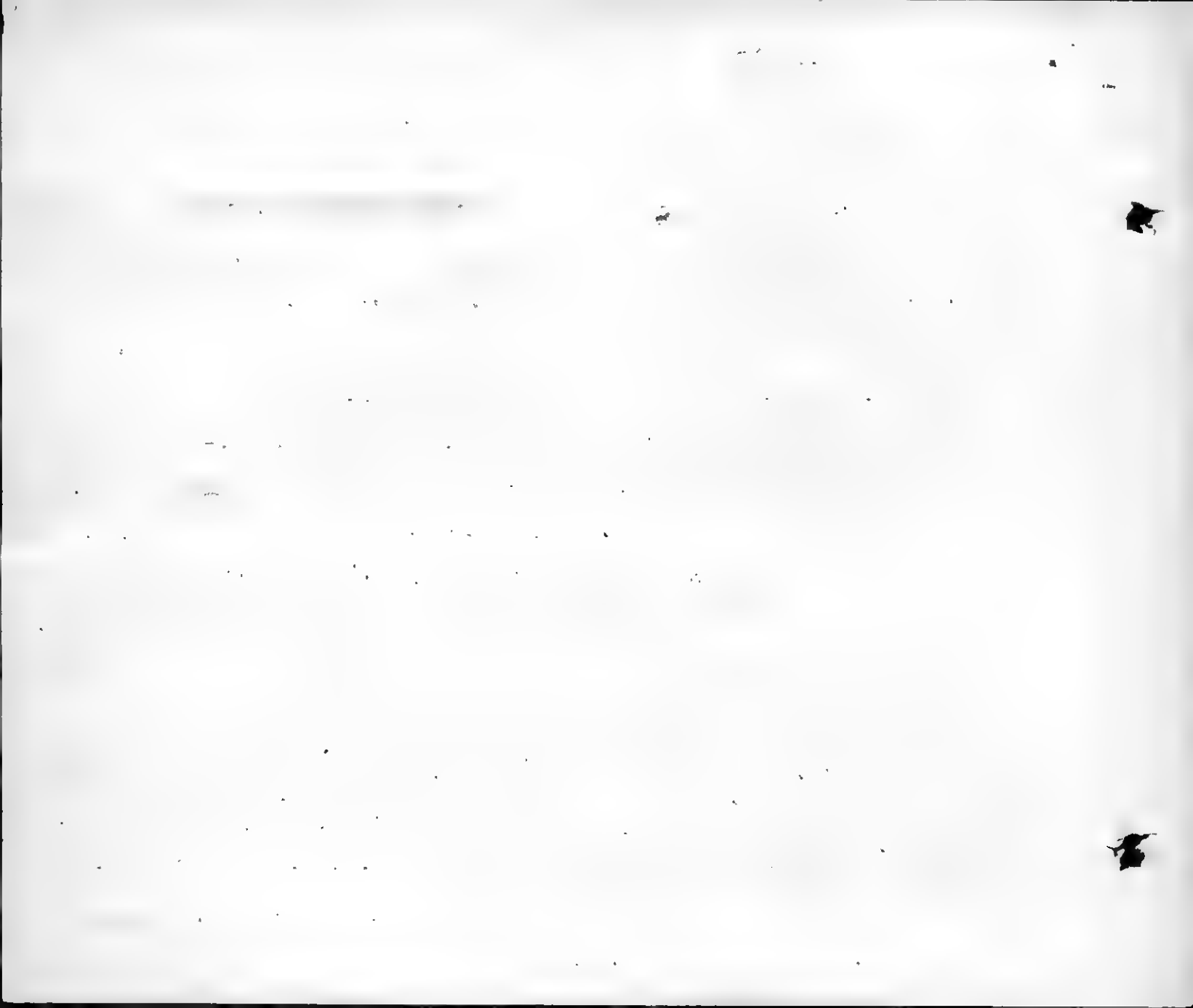
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3113 Ferndale Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pauline Middle A Last Wighington		4. DATE OF DEATH Month Dec. Day 29 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1920
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 3 Days 4 Hours Min. 	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Paul V. Reardon	
14. MOTHER'S MAIDEN NAME Minnie I. Hill		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		INFORMANT Victor E. Wighington, Jr.-Husband-	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 1950 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HEPATIC METASTASES DUE TO (c) CARCINOMA, RIGHT ADRENAL GLAND		INTERVAL BETWEEN ONSET AND DEATH 18 HRS. 3 MOS. 9 MOS.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/11/1959 to 12/29, 1959 , that I last saw the deceased alive on 12/29/1959 , and that death occurred at 7:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Tuohy		ADDRESS (Street, city or town, state) DATE SIGNED 7720 WISCONSIN AVE BETHESDA 14, MD. 12/29/59	
PHYSICIAN'S NAME (Type) John H. Tuohy		7720 Wisc. Ave. Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/4/60	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR JAN 4 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

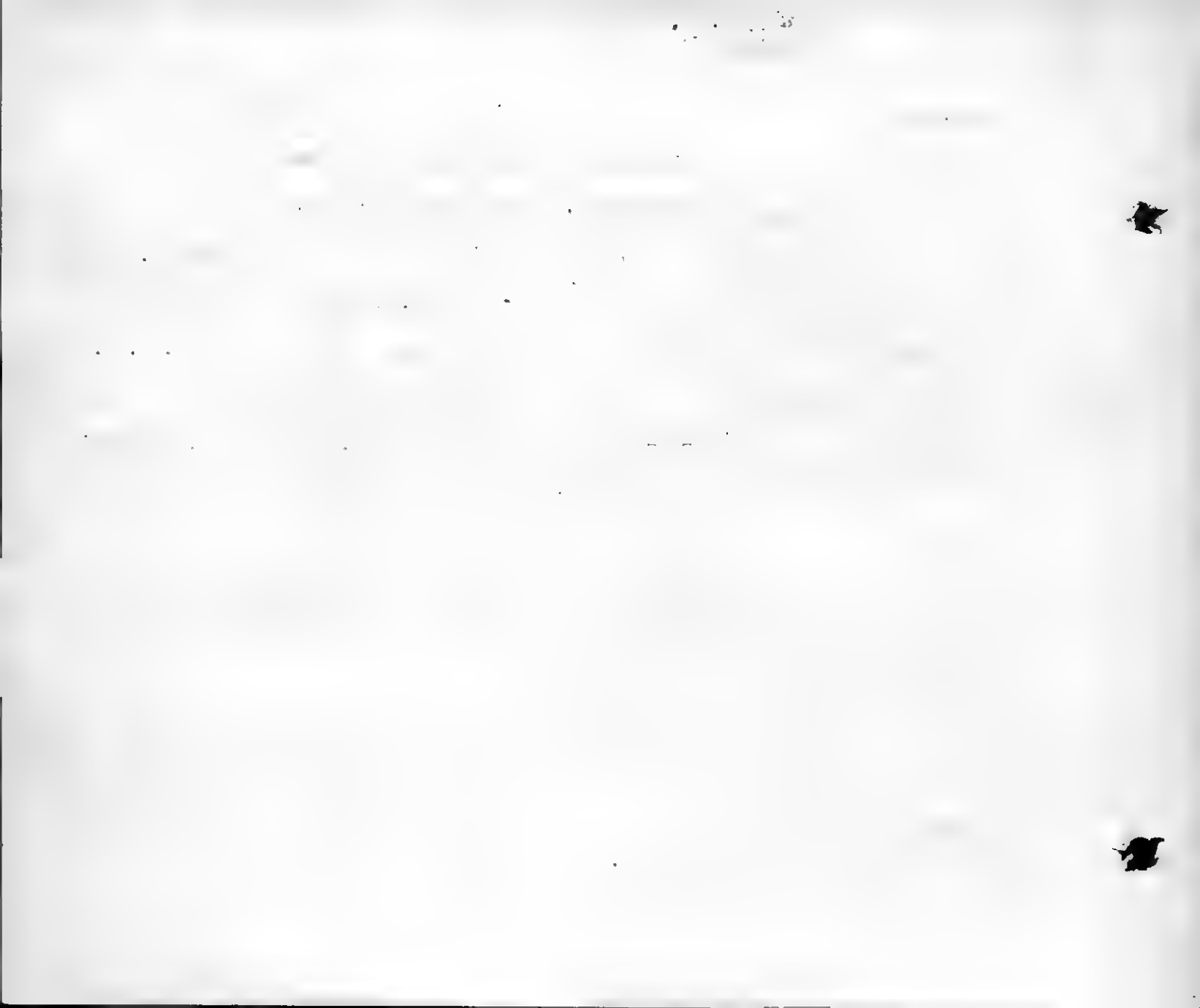
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CERTIFICATE OF DEATH

Reg. Dist. No.

13970

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>30 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>5868 South 1st Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jerry</u> Middle <u>Lee</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1959</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>January 28, 1940</u>		9. AGE (In years lost birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Food Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Iradell David Williams</u>			
14. MOTHER'S MAIDEN NAME <u>Dolores Cornelia George</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO <u>403-50-5513</u>		INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Subarachnoid Hemorrhage</u> DUE TO (b) <u>Acute Pulmonary Edema</u> DUE TO (c) <u>Acute Myelogenous Leukemia with massive enlargement of spleen, liver, lymph nodes and kidneys</u> 9 months Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>November 6, 1959</u> , to <u>December 6, 1959</u> that I last saw the deceased alive on <u>December 6, 1959</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Arthur R. Rothman</u> M.D.		<u>The Clinical Center</u> <u>12/6/59</u>					
PHYSICIAN'S NAME (Type) <u>Arthur R. Rothman</u> M.D.		<u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRASTORAL</u>		22b. DATE THEREOF <u>12-8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. KENTON</u>			
22d. LOCATION (City, town, or county) <u>PADUCAN</u> (State) <u>KY</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. [Signature]</u>		ADDRESS <u>ARLINGTON, VA</u>		24c. REC'D BY REGISTRAR DATE <u>DEC 9 '59</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

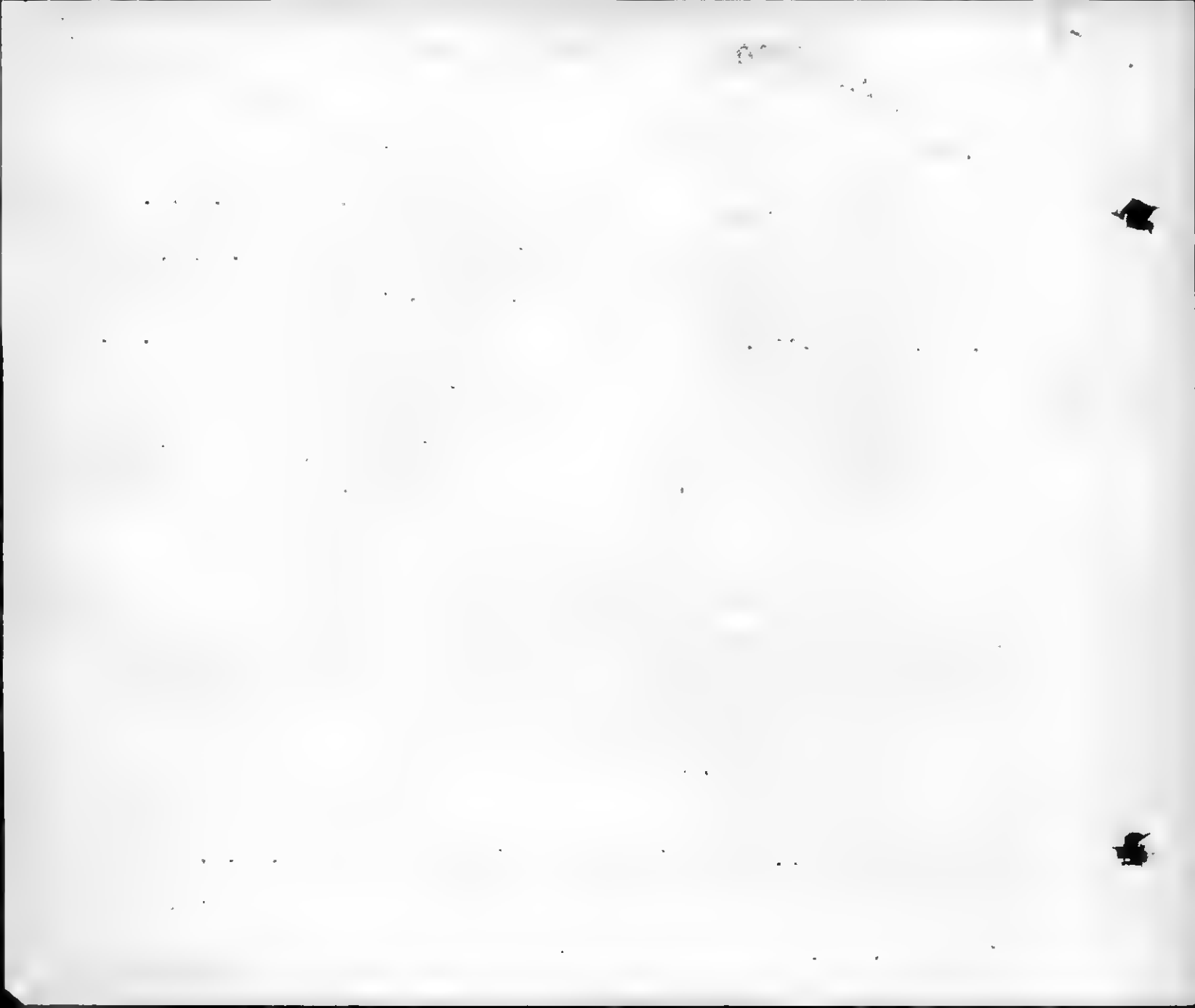
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CERTIFICATE OF DEATH

Reg. Dist. No. 13971

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia D.C. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle FRANCIS Last WILLIAMS		4. DATE OF DEATH Month Dec. Day 11 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Officer-VA. Adm.		10b. KIND OF BUSINESS OR INDUSTRY Govt- Retired	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank Williams		14. MOTHER'S MAIDEN NAME Sarah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Son		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20, 1947 to Dec 11, 1959 that I last saw the deceased alive on Nov 28, 1959 , and that death occurred at 2:54 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William L. Howell M.D.		ADDRESS (Street, city or town, state) 5401 Western Ave N.W. Wash D.C. DATE SIGNED 12/12/59	
PHYSICIAN'S NAME (Type) William L. HOWELL		5401 Western Ave. N.W. 12/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur B. Knott	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14001

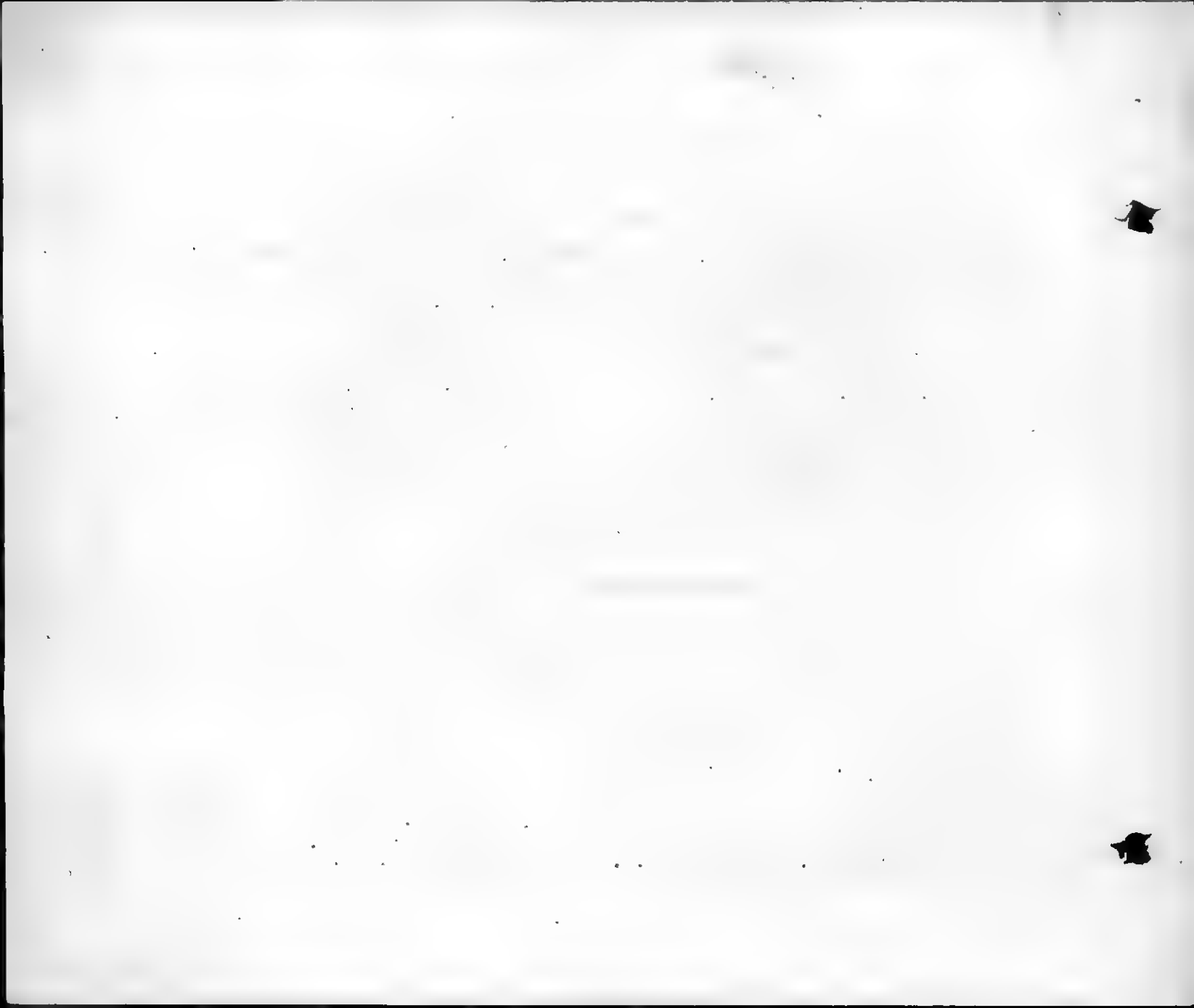
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Y	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home		d. STREET ADDRESS 4823 Earlestone Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM C. WORTHINGTON		4. DATE OF DEATH Month December Day 21 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1880
9. AGE (In years last birthday) yrs 78		IF UNDER 1 YEAR Months 11 Days 25	
IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Life Insurance salesman -		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George Y. Worthington		14. MOTHER'S MAIDEN NAME Nancy Taliaferro	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 579-268-348	
INFORMANT 13308 Okinawa Avenue, Rockville, Md.		Mrs. George Dickson - Daughter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diverticulitis, Colon DUE TO (c) Diverticulosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 19 , 1959, to Dec 21 , 1959, that I last saw the deceased alive on Dec 21 , 1959, and that death occurred at 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord St. Kensington, Md. DATE SIGNED Dec 21, 1959			
ACTUAL SIGNATURE Robert T. Thibadeau		DATE SIGNED Dec 21, 1959	
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-24-59	22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery	22d. LOCATION (City, town, or county) (State) Alexandria, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE DEC 28 59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

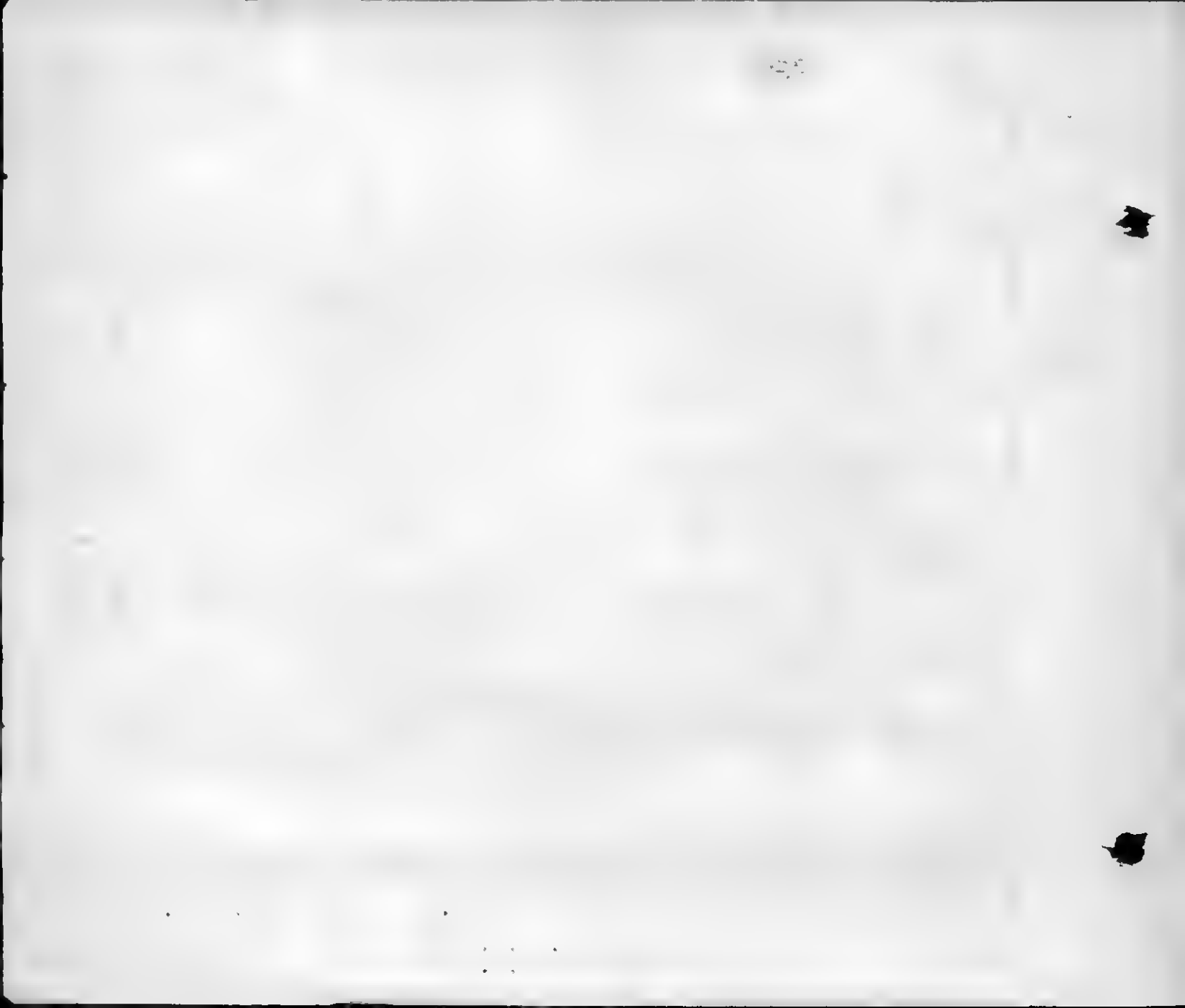
Reg. Dist. No. 13973

14002

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>9638 Dewmar Lane</u>				d. STREET ADDRESS <u>19638 DEWMAR LA.</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES ALBERT ZANNER</u>				4. DATE OF DEATH <u>DEC. 7 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 21 1872-86</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JEWELER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM ZANNER</u>				14. MOTHER'S MAIDEN NAME <u>ALWINA WEISS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>A.W. ZANNER S.R. - SAME</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Pulmonary Congestion</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan 27, 1950</u> to <u>Dec 6, 1959</u> that I last saw the deceased alive on <u>Dec 2, 1959</u> and that death occurred at <u>5:50 a.m.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Luther H. Snyder</u> M.D. <u>915 - 19th St. N.W., Wash. D.C.</u>				<u>12/7/59</u>			
PHYSICIAN'S NAME (Type) <u>LUTHER H. SNYDER</u>				<u>Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>DEC 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

13974

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2900 Peregow Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lydia G. C. Zing		4. DATE OF DEATH 12 10 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-29-83 ?
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MORGAN WATERS		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WMJ. COE	
17. INFORMANT WMJ. COE		Address 2900 PEREGOW DRIVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) ASCVD DUE TO (c) ASCVD			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 1957, to Dec 10 , 1959, that I last saw the deceased alive on Dec 9 , 1959, and that death occurred at 9:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herold W. Beeman		DATE SIGNED 12/10/59	
PHYSICIAN'S NAME (Type) Kensington, Md		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/14/59	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	22d. LOCATION (City, town, or county) (State) SUITLAND MD
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan		24a. REC'D BY REGISTRAR DEC 15 '59	
ADDRESS 317 Pa. Ave S.E.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13975

Reg. Dist. No.

14004

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3100 Brandywine St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Zirkin</u> Last <u>Zirkin</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>1959</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2.27.05</u>		9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR: Months <u>54</u> Days <u>54</u> IF UNDER 24 HRS.: Hours <u>54</u> Min. <u>54</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fire business</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retail</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>					
13. FATHER'S NAME <u>HYMAN ZIRKIN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH HARRIS</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Wife SAME AS ITEN 2</u>		17. INFORMANT <u>Wife SAME AS ITEN 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>4.20.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Frank J. Brosehart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED					
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-27-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>				22b. DATE THEREOF <u>12/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>				22d. LOCATION (City, town, or county) <u>PRINCE GEORGES CO. MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler's Sons</u>						ADDRESS <u>Wash. D.C. 1756 Pa. ave. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Funes</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar in the office of the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar in the office of the funeral director, cremation or removal.

